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ABSTRACT

This report highlights initiatives and accomplishments of the National Maternal and Child Health (MCH) Resource Center on Cultural Competency and a related consortium of 12 states and the District of Columbia from October 1992 through September 1995. Following an introductory section, the first chapter focuses on the role of the National MCH Resource Center on Cultural Competency. Next, eight guiding principles or assumptions are listed. The following chapter discusses factors identified by state representatives as important in developing cultural competency. Among 13 facilitating factors are support from high level administration, collaboration with the Office of Minority Health, training for all levels of staff, and a central, easily accessed location of all state resources. Among 13 barriers identified are lack of networking, staff turnover, conflicting priorities, government downsizing, and a narrow definition of "culture." The following section discusses lessons learned during this process in relation to gathering information, top management support, work group/task force, organizational assessment, long range planning, training, collaborators, implementation, consultants, and dissemination of information and experiences. Among seven appendices are a list of consortium state representatives, a paper detailing the cultural competency continuum, guidelines and assessment tools, a list of cultural competency trainers by state, and guidelines for a work group/task force. (Contains approximately 300 references.) (DB)

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Journey Towards Cultural Competency:

Lessons Learned

National MCH Resource Center on Cultural Competency
Texas Department of Health

U.S. Department of Health & Human Services
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HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau

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Journey Towards Cultural Competency

Lessons Learned

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Elizabeth Randall-David, Ph.D., an independent consultant and researcher, conducted interviews, compiled source documents, and completed the initial working draft.

Gianna Martella, Information Specialist, reviewed the document for structure, continuity, and consistency. Marcy Maldonado, Executive Assistant, had the responsibilities for all word processing and document design to bring distinctiveness and appeal to the finished product. Don Lawson, Program Administrator, assisted with the design requirements and proof reading. All of them went above and beyond the call of duty to produce this manual.

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To all of you, our sincere appreciation for this experience.

John E. Evans, M.H.A.
Principal Investigator

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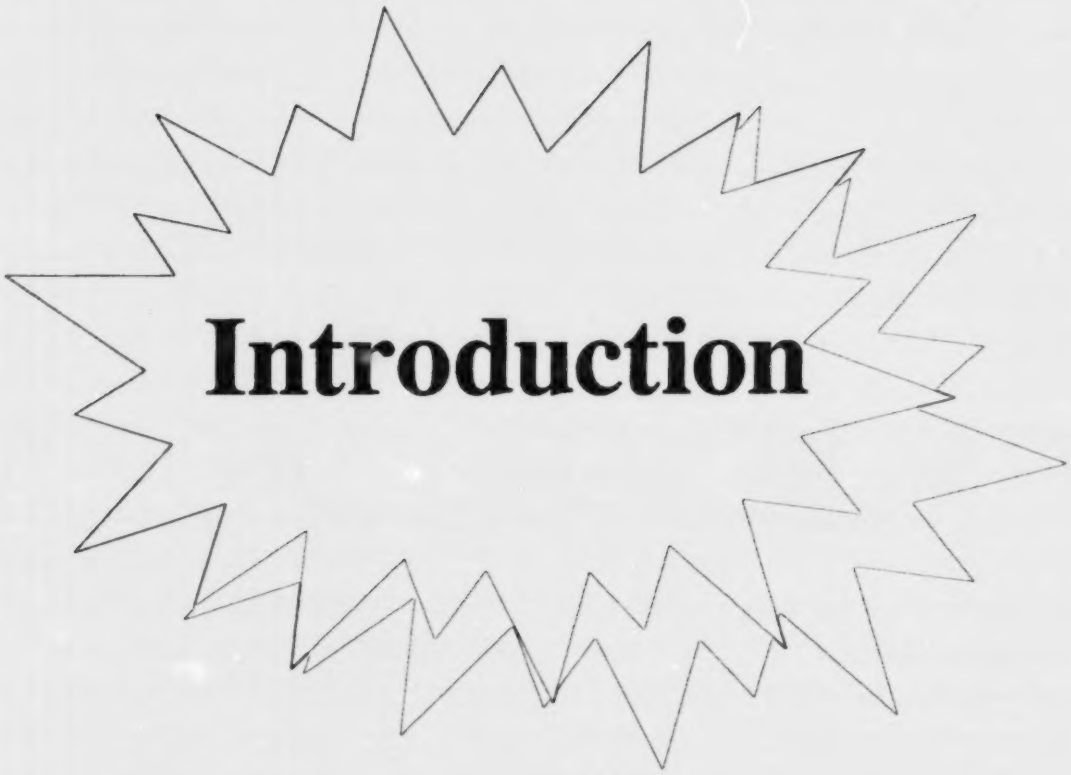

Introduction

Introduction

The United States has, and will continue to, become more ethnically and racially diverse. [1] In 1980, 74 percent of children under 18 years were White, not Hispanic; by 1990 this had declined to 69 percent, and projections suggest that by 2030, less than 35 years from now, only 50 percent of U.S. children will be White, not Hispanic. The population of minority children consists mainly of two groups (which overlap slightly). In 1990 Black children accounted for 15 percent of all children, with a projected increase to 18 percent by 2030. Hispanic children accounted for 12 percent of children in 1990, and is projected to double to 24 percent by 2030. [2]

Although Blacks and Hispanics account for the largest proportions of the one-third of American children in 1990 who belong to non-white or Hispanic minority groups, minority children trace their backgrounds to many different sources. One percent of U.S. children were American Indian, Eskimo, and Aleut in 1990, with the 2030 projection remaining at one percent. In 1990, 3 percent were Asian or Pacific Islander, with a projection of more than doubling to 7 percent by 2030. The Asian and Pacific Islander group in turn was very diverse in 1990, with 20 percent Chinese, 19 percent Filipino, 12 percent Korean, 11 percent Asian Indian, 10 percent Vietnamese, and 8 percent Japanese. The Hispanic population also was quite diverse in 1990, with 67 percent of Mexican origin, 12 percent Puerto Rican, 5 percent Central American, 3 percent Cuban, and 2 percent Dominican Republic.[3]

There is much to celebrate in the enrichment that diversity brings, but there are some added challenges as well. To meet the needs of families from these culturally diverse communities, organizations and agencies and the staff that comprise them are challenged to discover and implement innovative and effective strategies for working in a multicultural environment.

The federal Maternal and Child Health Bureau (MCHB) demonstrates a long commitment to culturally competent care for children with special health care needs. Through its block grants to states and a discretionary grant program entitled Special Projects of Regional and National Significance (SPRANS), MCHB encourages the development of family centered, community based, culturally competent, and coordinated programs for mothers, infants, children, and families. MCHB's position on promoting programs and policies that assure culturally competent services to children with special health needs and their families is:

> The Maternal and Child Bureau develops, implements, and monitors a nationwide program to improve the health of mothers, infants, children, youth, and children with special health needs in concert with the Year 2000 National Health Objectives. The Bureau administers a program of block grants to states to enable them to develop a plan, based upon a needs assessment, to promote the health of all mothers and children, and to provide quality health care services through a system of care that is family-centered, community-based, culturally competent, and coordinated for all children and their families. The block grant program assures health care services to low income populations who otherwise would have limited access to such services.[4]

The Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Public Law 101-239 amended Title V of the Social Security Act to extend the authority and responsibility of the MCHB to fully address the needs of children. OBRA '89 also redefined the mission of the state programs for Children with

Special Health Care Needs (CSHCN) under the MCH Services Block Grant. It "provided an opportunity for Maternal and Child Health/Children with Special Health Care Needs (MCH/CSHCN) programs to assess needs and gaps in services, especially for culturally diverse populations. It also provided for the development of statewide systems of accessible, acceptable, available, affordable and appropriate health care for all mothers and children, regardless of race, ethnicity, or culture. In addition, it provided the opportunity to develop permanent systems of care that are responsive to the values, traditions, and needs of the various cultural groups served, and to assure competent planning, delivery and evaluation of services. [5]

Beginning in 1990, MCHB convened working groups with directors from selected state CSHCN programs (or their designated representatives) and other interested and knowledgeable individuals. They discussed strategies that states could employ in meeting their newly expanded mission of improving health care delivery and related services to children from culturally diverse communities. The states participating in these early discussions, as is true today, were in varying stages of development in their level of cultural competence. It became clear that a defined and coordinated approach toward cultural competency guided by MCHB and CSHCN leadership would benefit State CSHCN programs.

In 1992, MCHB issued a call for proposals to establish a NATIONAL MCH RESOURCE CENTER ON CULTURAL COMPETENCY with the purpose of providing state CSHCN Programs and SPRANS projects with technical assistance and consultation; opportunities for networking;

useful tools and products related to cultural competence; training via workshops and conferences; access to a resource library; sharing of information; and development of databases in collaboration with other MCH resource centers.

The materials and training sessions, to be designed, were to assist the states in developing culturally competent systems of care that address:

1. the elements of cultural competency created at the state and community levels within the framework of family-centered care;
2) the role of the state agency program for CSHCN in relation to the development of a system of care that is culturally competent and community based; and
3) linkages between community and parent networks and the specialized services in the state.

The grant application guidance defined cultural competence and introduced eight essential elements that: "contribute to a systems'/agencies' ability to become more culturally competent. Each of these elements must function at every level of the system: policy, administration, practices, and advocacy." [6] Cultural competency refers to a program's ability to honor and respect beliefs, interpersonal styles, attitudes, and behaviors of families who are clients, as well as the multicultural staff who are providing services. It incorporates these values at the levels of policy, administration, and practice. [7]

The MCHB uses the term "cultural competency" for programatic reasons. Cultural sensitivity basically means knowing that cultural differences as well as similarities exist, without assigning values, i.e., better or worse, right or wrong, to those cultural differences. One needs to move to

another level - that of cultural competence - to apply this sensitivity in planning, implementing, and evaluating service systems that are family-centered and at the community level. Competency implies more than a knowledge of beliefs, attitudes, and tolerance. Competency implies skills which help to translate beliefs, attitudes, and orientation into **action** and **behavior** in the daily interaction with children and families.

The eight essential elements, enunciated by MCHB, that contribute to a system's/agency's ability to become more culturally competent are:

- conduct needs assessments for service planning purposes
- value diversity
- have the capacity for cultural self-assessment
- be conscious of the dynamics inherent when cultures interact
- institutionalize cultural knowledge via policies, administration, and practices
- develop adaptations to diversity when necessary
- separate the effects of poverty and geographic ramifications from cultural values
- guard against creating stereotypes in an effort to be culturally competent.

Cultural characteristics must always be viewed within the context of each individual family. Gaining knowledge of other groups should be used to broaden our perceptions and eliminate misconceptions, not to assign fixed characteristics to groups of people. In addition, it must be remembered that within cultural groups, there is much diversity.

The three-year grant to establish The National MCH Resource Center on Cultural Competency was awarded to the Texas Department of Health and a consortium consisting of eleven states (Arizona, Colorado, Maryland, Michigan, Montana, New Mexico, New York, Oregon, Texas, Virginia,

Washington) and the District of Columbia. Pennsylvania joined the consortium in June, 1994, and Nevada established affiliation in October, 1994. (See Appendix A for names, addresses and telephone numbers of the contact persons for each state, as well as the staff of the National MCH Resource Center on Cultural Competency.)

This report highlights the diverse initiatives and many accomplishments of The National MCH Resource Center on Cultural Competency and the twelve states and the District of Columbia for the period October 1, 1992 through September 30, 1995. Often, one can learn as much from what didn't work as well as what did. Thus, this document explores not only the helping, but also the hindering forces, as state representatives attempted to move their staff and agencies toward greater cultural competency. It must always be emphasized that moving towards cultural competency is a continuous process that requires a multi-faceted and multi-level approach. This report will discuss the various approaches utilized, the many levels on which the initiatives were launched, and the key players needed. We hope that other organizations and agencies can benefit from the lessons learned from the consortium participants' experiences in their journey toward greater individual, agency, and system cultural competency.

Some observations of the Center's experiences by the Principal Investigator is provided as a separate document entitled "An Epistemology of the Journey Toward Cultural Competency." A theory of the nature and principles of cultural competency training procedures, standards, and outcomes is explored based on the experiences of the National Maternal and Child Health Resource

Center on Cultural Competency activities. The focus provides an assessment of the realities of implementing change relating to organizational settings and individual behaviors.

Copies of the Epistemology may be acquired from the Texas Resource Center on Cultural Competency if it is not available with this publication.

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1. Bureau of Census, 1980

2. Day, Jennifer Cheeseman, "Population Projections of the United States, by Age, Sex, Race, and Hispanic Origin: 1993-2050." U.S. Bureau of the Census, Current Population Reports, Series P25-1104 U.S. Government Printing Office, Washington, D.C. 1993

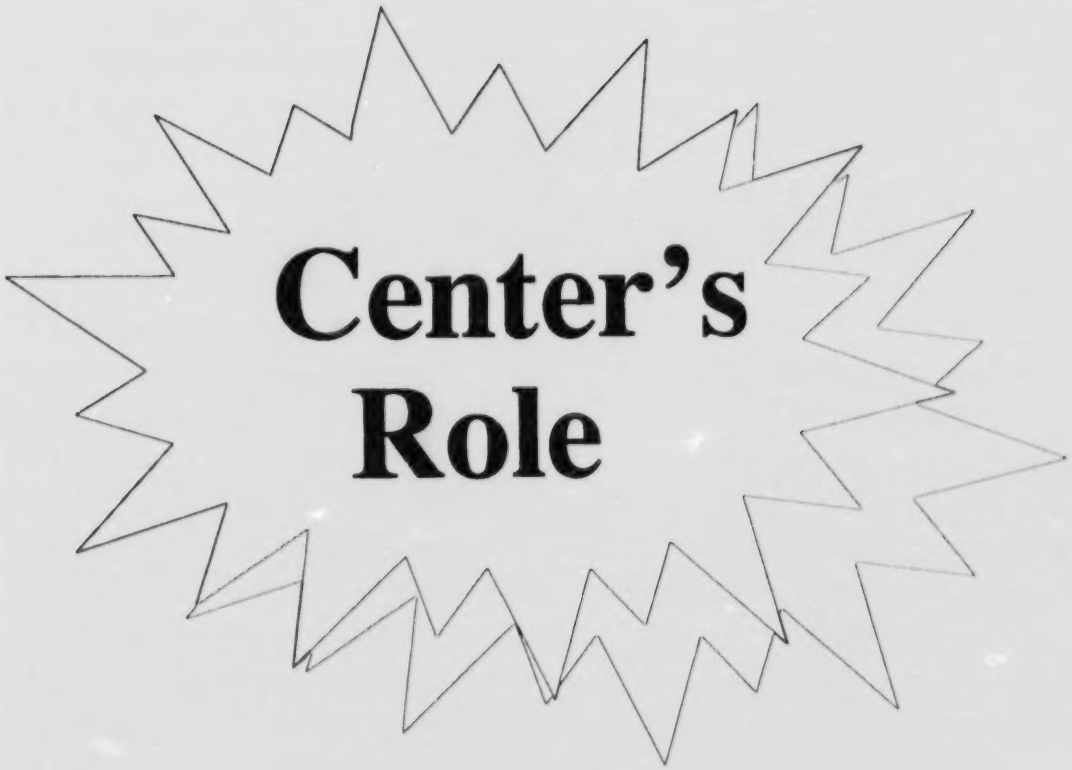
3. Hernandez, Donald, J., "We the American Children," U.S. Bureau of the Census, Series WE-10, U.S. Government Printing Office, Washington, D.C. 1993

4. This is an excerpt from MCHB's mission statement when the grant was in effect.

5. *Improving State Services for Culturally Diverse Populations: Focus on Children with Special Health Needs and their Families*, Work Group Report, 1990

6. "Grant application Guidance for a National Maternal and Child Health National Resource Center for Cultural Competency" Spring, 1992, Habilitative Services Branch, Division of Services for Children with Special Health Needs, Maternal and Child Health Bureau, HRSA, USPHS, DHHS, Washington, D.C.

7. Roberts, R., et al., *Developing Culturally Competent Programs for Families of Children with Special Needs*, 2nd Edition, Georgetown University Child Development Center, Washington, D.C., 1990 [Monograph].)


Center's
Role

The Role Of The National MCH Resource Center On Cultural Competency

The mission of this National Center during its funding period was to improve the quality of care and effectiveness of leadership in state CSHCN agencies by creating culturally competent systems of care through policies and procedures, staff training, and service delivery. The Center accomplished this mission through the following goals and objectives:

Goal 1: Assure that state procedures and policies for programs for children with special health care needs include provisions for delivery of culturally competent services to children and families.

- Objective 1: Develop and distribute principles of culturally competent care;
- Objective 2: Suggest to states policies and procedures that reflect principles of cultural competency;
- Objective 3: Monitor and provide consortium states with technical assistance for implementation of policies and procedures;
- Objective 4: Distribute organizational needs assessment tools.

Goal 2: Assure that Title V CSHCN staff is culturally competent.

- Objective 1: Develop and distribute assessment instruments to identify training needs for key staff;
- Objective 2: Develop and distribute training material for key staff;
- Objective 3: Provide training and technical assistance to state staff.

Goal 3: Implement culturally competent services through policy, services, and training to families of children with special health care needs in selected communities.

Objective 1: Develop and implement demonstration projects as models for culturally competent care;

Objective 2: Review policies and procedures in target communities to document the effects of policy changes;

Objective 3: Model the importance of parental input by inclusion of parents on Executive Committee of the Center.

The National Resource Center also provided the consortium states with funding for trainers, presenters, consultant services, and the purchase and development of materials to support their cultural competence efforts. In addition, the Center assisted the consortium states and other interested states and agencies with the following:

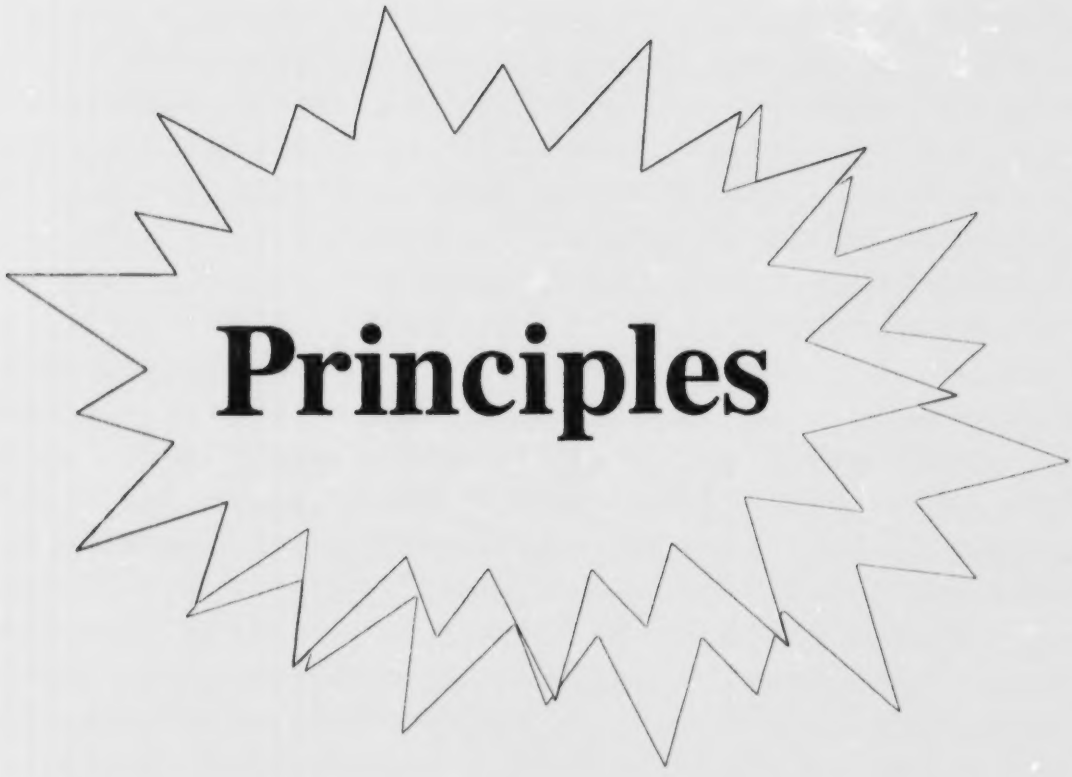
a. provided a toll free number for information and material requests;

b. established a clearinghouse for resources relating to working with culturally diverse communities and clients;

c. provided training and technical assistance relating to moving the states' CSHCN programs towards cultural competence including work with the U.S. Public Health Regional offices, as well as community-based CSHCN programs;

d. produced a quarterly newsletter to share information among the consortium states;

e. sponsored conferences and meetings designed to provide opportunities for states to share their experiences and learn new strategies for moving toward cultural competency.


Principles

Guiding Principles or Assumptions of Culturally Competent Programs

One of the first tasks of the newly created National Resource Center was to develop some guiding principles that would be used as "beacons" or "benchmarks" by those individuals and organizations aspiring to be culturally competent. A research of the literature pertaining to culturally competent organizations and services yielded the following observations. [1]

- Cultural competence, on a system's level, requires a comprehensive and coordinated plan that includes interventions on the individual, policy, programmatic and structural levels. It needs to be congruent with, and an integral part of, the overall mission of the organization.

- Cultural competency refers to the effectiveness and efficacy of a multicultural work force as well its functional interactions with a culturally diverse client group.

- Cultural competence is a dynamic, on-going process - not a goal or an outcome. Often it is said that it is "a journey not a destination". It is a continuing process of growth in knowledge, experience, and understanding.

- Cultural competence is never perfect or permanent and requires a long term commitment.

- Since organizations are often slow to change, there is no single activity or event that will ensure the cultural competence of an agency or staff. In fact, a one-time single activity reinforces the notion that "we've done that, now the problem is solved".

- The entire organizational staff must be trained. It is not sufficient for front line staff to enhance their cultural competence in the absence of similar efforts on the part of administrators, managers and policy makers.

- Cultural competence requires more than a knowledge about racial, ethnic, religious, gender, and sexual preference differences. It requires application of this knowledge in specific behaviors, policies and practices that acknowledge, respect, and value the integrity of clients and staff from all cultural backgrounds.

- Cultural competence also requires and values the active participation of clients and communities at all stages of program design including development, implementation, evaluation, and policy making.

CSHCN programs (and other agencies and organizations) can better meet the needs of the children receiving their services by using these principles in an effort to enhance their own cultural competency. A useful model for examining cultural competence is the one developed by the CASSP (Child and Adolescent Service System Program) Technical Assistance Center at Georgetown University. It conceptualizes the move towards cultural competence as a continuum

beginning with cultural destructiveness at one end and moving towards cultural proficiency at the other end. A complete description of this model and the characteristics for each point on the continuum are described in Appendix B. It is important to underscore the notion that movement along this continuum is often not linear and can be slow. For example, an organization can move back and forth on this continuum as it struggles with organizational change. Patience, persistence, and understanding are all essential ingredients in this change process.

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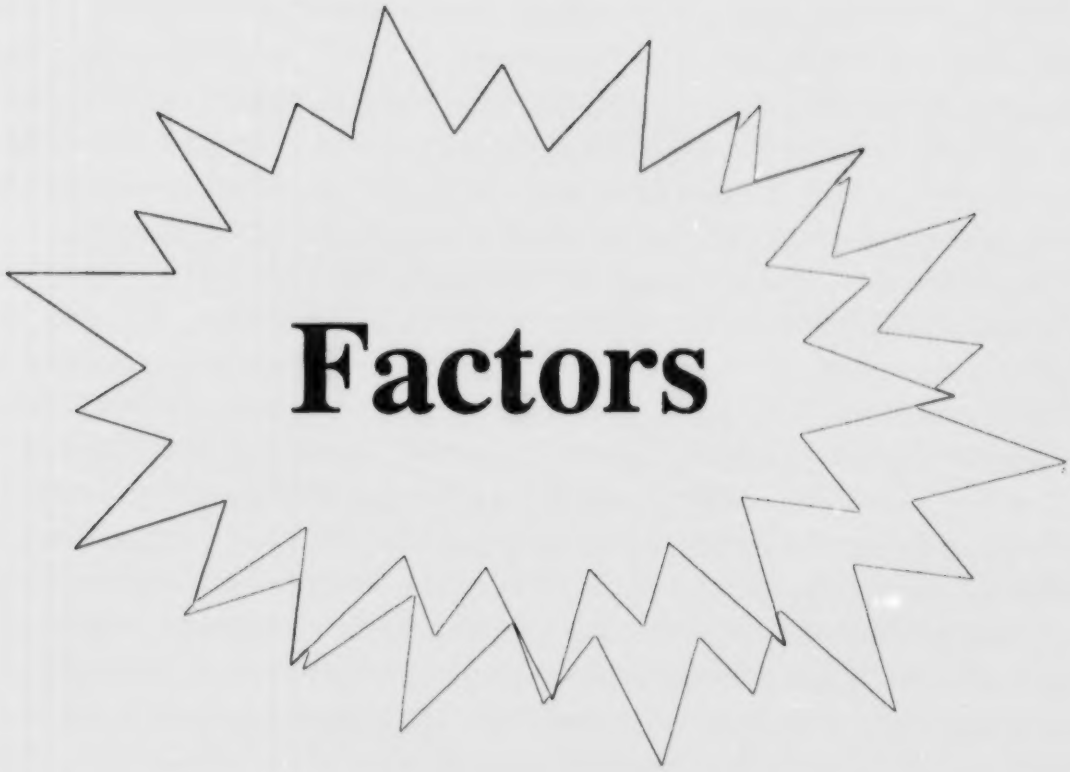
1. It should be noted that these observations not only represent the experiences of many human services organizations, they are also extracts from human interactions between different attitudes, values, and social mores.


Factors

Factors To Consider In Developing Cultural Competency

Interviews were conducted with staff from each of the consortium states in order to ascertain what they perceived to be the major factors which facilitated their efforts in moving toward cultural competency and which factors hindered their efforts. The journey towards cultural competency is a complex one that involves many different players and requires multiple and varied approaches in order to be effective. Listed are areas which the state representatives felt were major **facilitating or helping factors.**

Support from high level administration was critical to the efforts of many states. Especially important was the support of an administrator at the highest policy and decision making level. This person was able to promote the concepts and activities of cultural competency by:

a. validating the importance of the initiative;

b. supporting time for staff to plan and implement cultural competency activities and attend trainings;

c. providing funding for cultural competency activities (i.e. staff training and materials/ resource development);

d. assuring cultural competency principles were discussed at high administrative levels;

e. assuring changes were implemented at the administrative and policy levels.

Development of a department-wide task force or work group was instrumental in providing a mechanism for staff from a variety of programs to come together to work on cultural competency issues. It provided a broad base of support and opportunity for many people to participate and share responsibility for agency-wide cultural competency issues. States whose cultural competency efforts were exclusively the purview of the CSHCN program felt that other programs perceived cultural competency as "their pet project" rather than as an important issue that cuts across programs/sections/departments.

Designation of a lead person to coordinate activities of the workgroup proved to be instrumental, over time, in keeping the group focused. A number of consortium states indicated that the work group kept its momentum and focus when there was a designated staff person with the responsibility of creating agendas, scheduling meetings, and developing tasks. It is also important for the work group to recruit mid-management level staff with special interest, knowledge, and experience in cultural competency issues to commit to attending regularly scheduled meetings. Management level representation is important to reiterate the importance of cultural competency in the work force.

Collaboration with the Office of Minority Health (where it exists) and other departments doing policy and development, outreach, and service provision to culturally diverse communities and clients. These collaborative coalitions further enhanced and validated the efforts of the agency workgroup by providing an important linkage as well as additional support, resources, and ideas for approaches and intervention. .

Having a vision of cultural competency principles incorporated into everyday work of the program, rather than as a separate initiative, enabled staff to appreciate the far reaching importance of this work. For example, some states included cultural competency standards in Requests For Proposals, local health department contracts, agency and individual work plans, and procedure manuals.

The importance of training of all levels of staff was mentioned by almost all consortium states. Training took the form of specially designed workshops, incorporation of cultural competence training into on-going conferences, e.g., annual MCH conference; brown bag lunch groups; special presentations by persons from culturally diverse communities at regularly scheduled staff meetings; attendance by staff at other workshops on cultural diversity; and participation of staff in community cultural events.

> *Note:* Some states started training at the local level with health departments and programs and some started with central and regional office staff. All agreed that staff at all levels needed training by a skilled and non-judgmental trainer.

A central, easily-accessed location of all state resources including hand-outs, materials, lists, videos, guidelines, and model program descriptions facilitated sharing of resources related to cultural competency.

The importance of a network of parents, (including those representing diverse populations, advocates, community leaders, and concerned citizens to serve on advisory committees/task forces; review documents, brochures and hand-outs; review policies; and provide training to staff was a key element to a successful cultural competency initiative.

The importance of receiving **financial assistance, resources, and technical assistance from the Resource Center** was described by many programs as an important help in moving their cultural competency efforts forward.

Networking and learning from other states in the consortium was critically important in sharing ideas, support, and problem solving.

Identification of consultants knowledgeable about Title V, the state system, and cultural diversity issues was critical in helping programs operationalize cultural competency principles highlighted during staff training and in helping to translate these concepts into specific actions and products.

Establishing and renewing **personal relationships** with individuals of different cultures inside and outside of the work environment to garner support for the cultural competency initiative was invaluable in moving this important work onto the agendas of key administrators and policy makers.

Technical assistance and resource support from the regional MCH staff and the federal MCH project officer in addition to what was available from the National Center facilitated the cultural competency efforts of some states.

The downside of all the items mentioned as facilitating forces could be seen as obstacles with other state staff. Barriers encountered include the following:

- **lack of networking** with other staff members.
- **negative attitudes** on the part of administrators as well as middle managers who are and remain unsupportive of the cultural competency initiative.
- **staff turnover** at all levels of state government.
- **lack of adequate time and financial resources** for training and work group meetings.
- **reorganization within state government** which led to the need to redefine activities, additional training, and reluctance to begin new initiatives of any type, including cultural competency.
- **belief that cultural competency was not a top priority** because the numbers of people of color were relatively low in relation to the total population.
- **conflicting priorities** for staff time and resources.
- **government downsizing** leading to elimination of some staff positions and redesign of current staff job descriptions so that staff felt overloaded and resistant to assuming additional assignments and new efforts.

- **lack of coordination and communication** among various state programs and initiatives that have similar goals and common client groups.
- the **autonomy of local health departments** can make it more difficult for state office staff to introduce cultural competency initiatives at the local level.
- a **narrow definition of "culture"** to include only racial and ethnic minorities rather than a broader definition which includes individuals from religious and socio-economic backgrounds, sexual orientation of individuals, rural residents, etc., makes it more difficult for some staff to "sell" the concepts of cultural competency to other staff.
- **a perceived narrow focus on "children with special health needs"** rather than "all children" or "all MCH clients" or "all Department of Health clients", make it more difficult for some staff to "sell" the concepts of cultural competency to other staff.
- **difficulty locating qualified consultants** to work on implementation of the cultural competency principles on a policy and procedure level.

In order to optimize efforts in implementing cultural competency initiatives, it will be helpful to consider these barriers and the lessons they presented to the consortium states. In the next chapter, the consortium representatives describe the steps they took toward cultural competency and the lessons they learned so others might benefit from their experience and hindsight.

Lessons
Learned

Lessons Learned

The process of moving an organization or agency towards cultural competency is not an easy one. There are numerous steps that should occur to assist in this process. The National Resource Center's consortium states outlined these steps, including the "lessons learned" and recommendations on how to accomplish them.

It is difficult to outline a linear strategy proceeding sequentially from one step to the other. However, from experience reported by consortium members, it appears that certain steps should precede others. Several different steps can occur simultaneously. Not all of the states in the consortium have completed all of the steps. The lessons discussed below have been identified as being the key to facilitating this process, and it is recommended that **all** of these steps be included somewhere in a state's plan for developing a more culturally competent system. Following each lesson are examples from the states noted in italics.

1. Gathering Information

- Client

  a. Review existing data systems to determine if appropriate information is being collected to identify specific racial/ethnic groups. Ethnic groups should at a minimum be broken down into the following groups: White (not Hispanic), Black (not Hispanic), Native American, Hispanic, and Asian/Pacific Islander. Focus on the smallest subgroup possible that will still yield reliable statistics. (e.g., Hispanics can be broken down into Mexican Americans, Puerto Ricans,

Cuban Americans, Guatemalans, Salvadorans, and other Hispanics; Asian/Pacific Islander could be broken down into Chinese, Japanese, Korean, Vietnamese, Thai, Laotian, Hmong, Filipino, Hawaiian, Samoan, Tongan, other Asian/Pacific Islander). It will depend on the numbers of each ethnic/racial group in the state to determine the feasibility of breaking down the larger categories into smaller ones.

b. Utilize multi-method and multi-source data collection tools. Be sure to utilize case studies, focus groups, and other ethnographic and qualitative methods to fully capture the cultural values, attitudes, beliefs, and behaviors of clients from culturally diverse communities. These qualitative data can be combined with quantitative data such as population statistics, service utilization, health status, and client satisfaction surveys to form a more complete picture of clients from culturally diverse communities.

- Staff

a. Gather information on the race/ethnicity of staff in various agencies, including data on specific levels of employment (e.g., administrative, managerial, line staff, support personnel, etc.). These data are usually available in EEO reports required from agencies receiving federal funds.

b. Collect data on staff knowledge, attitudes, and skills relating to working in a multi-cultural work place and with culturally diverse clients (individual cultural assessments).

- Process Information
  a. Establish a baseline at the beginning of the effort towards increased cultural competency and measure progress against this baseline at least yearly.
  b. Both quantitative and qualitative data should be used in the process data collection effort.

- Collaboration
  a. Develop a collaborative partnership between researchers, practitioners, policy makers, and the community.
  b. Focus community level data on community strengths as well as needs.

Arizona developed procedures for obtaining input from families with children with special health needs in eight pilot communities through the following mechanisms: a) held town hall discussions with families to ascertain their perspectives on the strengths and barriers of the current system; b) conducted interviews with local leaders and providers (representatives from public health/ medical care, education, business, community leaders/elected officials, social service providers and advocacy groups) to ascertain their perspectives on the strengths and barriers of the current system; c) utilized parents to survey other parents to determine impact of child's health condition on family functioning. This data was used to establish a baseline to measure the success of the Office for Children with Special Health Care Needs interventions. Oregon established a consortium of researchers and people from culturally diverse communities to look at health services research and ascertain its relevance to communities of color. Montana's work group formed a task force to work with The Population Institute at the University of Montana in order to devise better data collection

methods for capturing information on Native Americans and chronic illness. Many states used the data describing culturally diverse communities to raise consciousness regarding the appropriateness and necessity of cultural competency initiatives. Some used demographic data describing staff diversity to highlight the need for targeted efforts to recruit, retain, and promote staff from culturally diverse communities.

2. Top Management Support

- It is recognized that "unless senior leaders understand what it [cultural competency] is about, what their own attitudes and biases are, and what the systemic issues of discrimination are [in their agency], they can't be effective leaders. And unless they lead, the [cultural competency] initiatives cannot be operationalized."[1] To request support from top administrators and policy makers, use their concerns and objectives to "sell" the importance of cultural competency. "Selling" points might include:
  a. Data indicating that racial and ethnic groups have a poorer health status, higher infant mortality and morbidity rates, under-utilize existing services, and are under-represented in the work force.
  b. Funding sources increasingly require a demonstrated commitment to cultural competency in order to receive grants, contracts, etc.
  c. Improving interpersonal communication skills can lead to a more efficient, productive, and effective work place.
  d. A diversified work force will increase creativity, problem solving capability, and connection to a wider array of resources and communities.

e. Services to culturally diverse clients and communities will be enhanced and improved.

f. It is a morally and ethically sound practice.

While all of the consortium states agreed on the importance and necessity of management support, Michigan has a unique approach. Legislators are invited into parents' homes to discuss issues related to care for their children with special health needs.

3. Work Group/Task Force

- The establishment of a working group or task force that is dedicated to the issue of cultural competency signals a real commitment on the part of the administration.

- The composition of a work group is critical and deserves careful consideration. From the consortium states' experiences, it seems the more diverse the work group is, the greater its impact and effectiveness. Diversity includes:
  a. staff from a variety of programs, departments, and projects;
  b. individuals representing ethnic, racial, and cultural backgrounds, as well as age, gender, educational level, sexual orientation, and other cultural factors;
  c. people from different levels of staff and different roles within the organization.

- It is recommended that a facilitator be elected by workgroup participants to provide the logistics and keep up the momentum. This person should possess a genuine interest in cultural competency issues as well as group facilitation skills.

- Rotating leadership within the group allows the feeling of ownership on the part of work group members.

- As in any group, the clearer the roles, responsibilities, and mission, the more productively and effectively the work group will operate.

- Having a regular meeting time that work group members can put on their schedules well in advance will help with consistent participation.

- All work groups reach plateaus from time to time. Listed are suggested strategies for re-vitalizing the participants:

  a. schedule a retreat that is facilitated by an outsider who can help the group appreciate their successes and plan ways to effectively and creatively approach challenges;

  b. build in activities that focus on professional development, e.g., paid attendance at cultural diversity conferences or leadership development workshops in other departments and/or states;

  c. invite someone from another state or department which can share their organization's experiences in implementing cultural diversity initiatives;

  d. hire an outside consultant who can lead the group in problem solving or brainstorming.

A sample of mission statements, goals, a membership screening questionnaire, and scope of work for a workgroup or task force are located in Appendix "E".

4. Organizational Assessment

- Often one of the first tasks that a work group will undertake is an organizational assessment. Although it may require the assistance of an external agent such as a consultant, its purpose is to help focus attention on specific attitudes, beliefs, and behaviors promulgated by or reflected in the organization. (Examples of conducting organizational assessments are listed in Appendix "C".) It is important to emphasize that regardless of the assessment tool used, those conducting the assessment need to approach it as a **process** and not as an **end point**.

- The assessment helps an organization become more aware of the many dimensions involved in cultural competency and points out areas needing improvement. A comprehensive assessment is carried out on a number of different levels: staff; administrative policies and procedures; organizational structure; and the relationship between the organization and the community and clients it serves.

- The organizational assessment should help indicate possible staff training needs.

- Upon completion of the organizational assessment, the work group can prioritize the identified problems and determine which areas will be addressed in the immediate future. This prioritization will lessen the feeling of being overwhelmed by the many identified problems and will help the work group develop a comprehensive plan for the organization.

While some states focused their assessment efforts on the individual staff member level, others, like Oregon and the District of Columbia, undertook an assessment of the entire organization.

5. Long Range Plan

- Generally, once an organizational assessment has been conducted, the work group develops a long range plan based on the assessment evaluation. This plan includes specific goals, objectives, activities, timelines, resources needed, mechanism for evaluating progress, and staff responsible for each activity. Goals for each individual or department builds in specific accountability.

- Eliciting input from agency staff not involved in the work group is an important part of prioritizing and developing a long range plan. Involving as many agency staff as possible promotes buy-in and ownership of the plan.

- In order to evaluate the progress toward long term and short term goals, an organizational review or evaluation should be performed on at least a yearly basis

since it is important to determine benchmarks of progress early in the effort.

Michigan, New York, Virginia and Washington were some of the states in the consortium that developed a long range plan that incorporated cultural competency goals at all levels of the organization.

6. Training

- Training of staff and providers, based on organizational and individual assessments, is an important aspect in moving an organization toward cultural competency. There are several different levels of training, including:
  a. Pre-readiness - which raises awareness of the need for cultural sensitivity and competency.
  b. Knowledge of one's own cultural values and beliefs and the biases one might bring when interacting with the cultural values of the clients and communities served by the organization.
  c. Increasing knowledge base regarding the cultural attitudes, beliefs, values, and practices of the clients served by the organization.
  d. Skill development in cross-cultural communication and service delivery.
  e. Advocacy training focusing on how providers can work with culturally diverse communities and clients to facilitate empowerment.
  f. Training in conflict resolution.
  g. Training on how to provide technical assistance and consultation to contractors/local agency staff concerning cultural competency issues.

The Chronically Ill and Disabled Children's Services Bureau of Texas requires all contracted case management staff offering direct services to the Bureau's clients to participate in cultural competency training that is selected or presented by the Bureau's staff. New York requires cultural competency objectives in work plans of case management projects which are funded through local health departments. Washington mandated staff (within one division of the Department of Health) to attend a one-day self-assessment training and strongly encouraged them to participate in a minimum of one cultural diversity training activity per year. New Mexico's employees of the Children's Medical Services are required to obtain at least eight hours of cultural training per year.

- Training for consumers of Maternal and Child Health services, especially those families receiving services for children with special health care needs, should not be overlooked as an organizational objective. While organization staff are targeted as legitimate recipients of cultural competency training, it should also be recognized and emphasized that collectively they comprise and represent an organizational culture. It is this culture of the organization that presents possible obstacles to recipients of its services. Given these observations and the recognition of obvious barriers such as "isms" (age, sex, class, race, etc.), language, and culture, it would be reasonable and inclusive to train consumers to recognize and negotiate the culture of the organization. Although members of the service organization may be made aware of these differences through cultural competency training, members of the consumer population are rarely if ever provided an opportunity to participate. The

inclusion of consumers in organizational cultural competency training, or providing community-based training through neighborhood charitable service or faith-based organizations could create some opportunities to:

a. increase organizational constituency and credibility;

b. promote outreach activities by including marginal participants and new residents or immigrants;

c. provide experiential learning for both staff and consumers regarding cultural differences;

d. collect and disseminate information regarding community needs and organizational services;

e. develop partnerships in achieving mutual objectives for services; and,

f. recruit and retain diverse staff to ensure cultural representation of community.

- The identification of skilled trainers is crucial. The most effective training is non-confrontational and conducted in a manner that creates a feeling of psychological safety for the trainees. Sources of potential trainers include:

  a. University based staff in anthropology, public health, sociology, social work, psychology, education, health education, etc.

  b. Trainers affiliated with, or recognized by, the National MCH Center on Cultural Competency

  c. Private trainers (see Appendix "D")

d. Community-based organizations serving racial/ethnic minorities

e. Parents of children with special health needs or other community residents from culturally diverse communities.

- A combination of different training approaches are needed for different individuals and levels of staff. Some staff respond better to experiential learning, others respond better to data based and more didactic approaches. Training always needs to be tailored to the audience. Administrators, by virtue of their job responsibilities, are often concerned about data and outcome, but their learning styles may be experiential. Ideally, staff should recognize their own culture and values, and be aware of the biases that their culture brings to the training sessions.

- Training needs to be reinforced with repeated opportunities and approaches. It should be conducted in numerous locations to increase accessibility. A one-time training event is not adequate.

- New employee orientation should include training on cultural competency.

- Training must be multi-level to ensure integration into all agency activities. Each of the following levels are important:

  a. Administrative and central office staff;

  b. Regional staff and local providers;

c. Consumers of services including parents of children with special health needs. Unlike workers attending a training, most consumers are not paid for their time spent in training. Therefore, providing funding for consumers to cover costs of travel, child care, and time is critical in assuring their participation.

- Informal as well as formal training opportunities are effective, e.g., attendance at cultural events such as pow wows, festivals, etc., in communities served by the organization.

- A resource library that includes books, journal articles, videotapes, audiotapes and other materials reinforces knowledge gained through training. It is helpful for these materials to be centrally located and easily accessible by staff at all levels of the organization, including local providers.

Almost all of the states in the consortium have provided staff training in order to increase awareness of their own cultural attitudes, values and beliefs, and to increase understanding of the cultural values, attitudes and beliefs of their clients. A needs assessment was conducted in order to ascertain the most appropriate training for the staff before planning and implementing a training series. Some states used a needs assessment developed by the National Resource Center and others used assessment tools developed by the consultants who provided the training. The most extensive assessments were conducted by the District of Columbia, New Mexico, Oregon, and Washington.

There was some variation in the topics covered, but generally the training focused on some or all of the following areas: definition of culture; elements of cultural competency; cultural competency continuum; cultural attitudes, values and beliefs of providers and their effect on services; cultural attitudes, values and beliefs of clients and their effect on the utilization of services; dynamics of difference; implications of the above on MCH services; and the culture of the organization.

Training was provided by knowledgeable staff within the agency, the National Resource Center's staff, and/or other local, regional or national consultants. Almost all states in the consortium offered training workshops; Texas and Washington organized brown bag lunches; New Mexico encouraged staff attendance at culturally diverse community events; and Oregon and Montana sponsored staff participation at conferences. New York and Michigan provided training for parents and other members of culturally diverse communities.

Texas utilized a unique approach for educating eligibility specialists. In order to increase their understanding and compassion, the CSHCN program gave them an opportunity to make home visits and learn more about the strengths and challenges faced by their clients.

7. Collaborators

- The consortium states learned that collaboration is an important function in putting their organization on the right track towards cultural competency. Collaborators may be found in both the public and private sector. They can provide technical

assistance, moral support, financial support, shared resources, and training, and they can facilitate accessibility to culturally diverse communities and clients.

Michigan, New York, Arizona, Maryland, New Mexico, and Texas collaborated with parents of children with special health needs to increase the effectiveness of their programs. Montana worked with tribal leaders to improve services to clients from the Native American communities in their state. Just as important, are collaborations within the state systems, such as: Office of Minority Health or its counterpart (Michigan, Montana, New York, Oregon, Virginia, Washington); Office of Civil Rights and Bureau of Human Resources (Texas); Department/Division of Developmental Disabilities (Arizona, New York); Local universities, e.g., School of Public Health (New York); School of Social Work (Texas); Medical School (Maryland); Population Institute (Montana); Regional Head Start Health and Nutrition Networking Initiative (Arizona).

Networking with and learning from other states in the consortium were highly effective. This was accomplished through meetings, conferences, telephone contacts, and technical assistance visits.

8. Implementation

- Long range plans should include implementation of culturally competent principles at the individual, policy, administrative, and service provision levels. The need to proceed with well thought out and carefully considered actions will facilitate any systematic change. Change is a **process** and doesn't happen overnight.

- Moving the location of the program/clinic to culturally diverse communities will improve access and acceptability for clients.

- Reflect the diversity of the communities the organization serves with the decor, posters, and reading materials in offices and waiting rooms.

- Increase diversity of the agency's governing board of directors, policy and decision making bodies, and consultant roster.

Michigan, New York, Arizona, and New Mexico made an effort to bring diversity into their governing bodies by selecting minorities to serve on their boards. District of Columbia, Michigan, Montana, New Mexico, New York, Oregon, Pennsylvania, Texas, Virginia, and Washington hired consultants from culturally diverse communities to train agency staff.

- Recruit and promote staff from culturally diverse backgrounds.

- Incorporate changes at the policy level to include:

  a. An organizational mission statement that demonstrates a commitment to cultural competency;

  New York's Department of Health broadened the mission of its Office of Affirmative Action and renamed it the Office of Diversity and Multicultural Services to reflect an expanded scope that includes the agency's responsibility to provide "quality health services which are accessible as well as culturally relevant to New York

States's increasingly multicultural/multilingual constituency."[2] Colorado incorporated a sentence on cultural competency into the program's mission statement.

b. Create organizational performance standards that reflect culturally competent practice;

A program outcome objective was written by the staff of Colorado's Department of Health to increase the number of children from different cultures served by the program. New York developed case management standards that incorporated cultural competency principles. Texas revised all case management contracts to include a new requirement that contractors provide culturally competent services to children with special health needs.

c. Develop job descriptions and performance appraisals to include the ability to work effectively with culturally diverse clients;

d. Develop personnel policies that are flexible and responsive to the needs of a diverse staff. Leave policies and insurance benefits should recognize the diversity of the work force;

Washington has done extensive work in this area.

e. Write policies and protocols for outreach to clients from culturally diverse communities;

Michigan developed a brochure entitled "From Words to Action: Notes on Serving a Culturally Diverse Population" which provides guidelines for working with culturally diverse communities and clients.

f. Mandate in policies that parents and consumers from culturally diverse communities be included to serve on advisory boards, task forces, work groups and other policy making bodies;

Michigan, New York, Arizona, Maryland, New Mexico, and Texas incorporated policies that included parent and consumer involvement.

g. Adopt dispute resolution and grievance procedures that are responsive to culturally diverse client groups and staff. It is important to recognize the inevitability of conflict between and among cultural mores when training diverse groups;

h. Instill a system with the local providers for monitoring grants, awards, contracts, and work plans to ensure the inclusion of cultural competency at the community level;

New York and Washington contracts with local vendors to provide direct services to clients. This monitoring system gives the staff at state level the ability to ensure the clients are receiving culturally competent services.

i. Incorporate cultural competency principles into guidelines, standards, procedure manuals, and other agency publications.

Arizona developed child care provider guidelines and individual family services plans. New York and Texas incorporated cultural competency principles in their case management contracts. Washington incorporated these principles in guidelines for use in service-delivery and grant writing.

- Implement changes in practice or programs to include the following:

a. Employment of interpreters and translators to work with non-English speaking clients will enhance the program's efforts towards a more culturally competent system of care;

New Mexico purchased Spanish/English medical dictionaries for use by local providers; New York employed bilingual case managers; Virginia hired Spanish-speaking interpreters, and had program materials translated into Spanish and certain Asian languages; Colorado, Maryland, New Mexico, and Texas developed interpreter and translator guidelines. (See Appendix "F" for examples.)

b. Agencies must ensure that their community needs assessments are culturally sensitive and they must involve parents and residents from culturally diverse communities in their conceptualization and implementation;

c. Special programs targeting clients from culturally diverse communities should be expanded and/or implemented;

Arizona established the Children's Information Center (a bilingual hotline) for families of children with special health care needs attempting to access services, and developed a Project OCSHCN Tsunami which contracts with 200 parents throughout the state to provide parental input, review documents and policies, and serve on advisory committees.

New York created "Partners in Health", made possible through a SPRANS grant that was funded by MCHB. It assists families caring for children with special health needs by linking them to local community service agencies, fostering self-help and mutual help networks, and training parents to be more actively involved in advocacy efforts.

Michigan, also through a MCHB funded SPRANS grant, developed "Project Uptown" (Urban Parents, Together Organizing Within Networks) to provide peer support for culturally diverse parents. Through this network, parents, siblings, and grandparents of children with special health needs are linked with peers who provide information, support, and friendship.

"Rural Oregon Minority Pre-Natal Project" is a five year demonstration project to assess and provide outreach and culturally competent care to Native American and

Latino women living in rural areas. Oregon also provides subsidies for local health department providers to attend "Northwest Voices: People in Action for Health Reform."

Washington offered mini-grants to local communities to increase health care access for low income mothers and children who are primarily from the African American and Native American communities.

A Kellogg funded project, "Cherish our Children", was granted to Montana for the purpose of using a community-based approach to address the problem of fetal alcohol syndrome among Native Americans.

d. Develop culturally and linguistically appropriate educational materials, consent forms, and other agency forms;

Programs in Arizona, New York, Washington, New Mexico, Colorado, and Texas translated their materials into languages that were appropriate for the population they served.

e. Use appropriate formats for communicating with clients from culturally diverse communities (e.g., community newspapers, tv or cable stations, radio talk shows);

f. Develop and utilize networks within culturally diverse communities, such as natural helpers, elders, traditional healers, religious and spiritual leaders;

g. Involve parents and clients from culturally diverse communities in all levels of program planning, implementation, and evaluation;

h. Collaborate with community-based organizations serving culturally diverse communities;

i. Develop culturally competent forms and approaches for intake, assessment, interviewing, case planning, and treatment.

9. Consultants

- It is recommended that agencies contract with outside consultants to assist them with their cultural competency assessment. This assures that biases and opinions will not interfere with the final recommendations, and allows staff to be more honest in their responses without fear of retaliation or termination.

- Decide what type of consultant the organization needs at the particular developmental stage. For example, some consultants have expertise in training but not in assessment or facilitation of group process.

- Before selecting a consultant, interview several using a standard format or set of questions. Consultants with prior experience working with culturally diverse communities and clients are most effective. Don't assume that a person of color will be culturally competent and innately have the skills to lead your organization towards cultural competency. Successful consultants integrate their knowledge and experience in cultural issues with their skills in communication, group process, facilitation, and organizational change. Consultants who have had experience working in/with a state system may better understand organizational strengths, challenges, and constraints than someone who has not had a similar experience. If at all possible, check references with others who have employed the consultant. Be clear as to what you expect of the consultant and obtain a written contract or agreement of the scope of work.

- A good consultant will facilitate a process in which organization staff and clients will define their own problems and strengths, and then brainstorm solutions and approaches. The consultant's role is **not** to "fix" things or to tell the organization what to do, but rather one of a facilitator or guide.

- Consultants will be most effective if they have an opportunity to interview or talk with a variety of staff and clients as part of their involvement with the organization. It is not sufficient for the consultant to interact only with managers or administrators. Participation of clients and communities served by the organization is critical to the success of the consultation.

- Possible sources of consultants are: University departments (anthropology, public health, sociology, social work, psychology, education, health education, etc.); consultants affiliated with, or recognized by, the National MCH Center on Cultural Competency; private consultants; minority community-based organizations with expertise in organizational development; Office of Minority Health staff or consultants; and organizations and associations that promote minority groups.

The National Resource Center provided a great deal of consultation to the states in the consortium either directly through training and technical assistance visits or through recommendation and sometimes funding for a local, regional or national consultant. Consortium states aided each other in their cultural competency efforts. For example, a consultant from Washington provided training and technical assistance to Virginia and Pennsylvania.

10. Dissemination of Information and Experiences

- Experiences of states and organizations which have embarked on the cultural competency journey were shared through the following mechanisms:
  a. Presentations at conferences and workshops;
  b. Papers published in academic, professional and community journals, and print media;
  c. A quarterly newsletter published by the National Resource Center;
  d. Training and technical assistance offered to others interested in this work.

Several consortium states developed products that were shared with other individuals and organizations. New York published a manual entitled "Partners in Health: Self-Help Mutual Support for Culturally Diverse Children with Special Health Needs and Their Families". The target audience is leaders of community-based organizations who have the interest and resources to assist families of children with special health needs by establishing a parent support group or responding in other creative ways. Although it is particularly geared to the leaders and natural helpers within culturally diverse communities, it has more general applicability. This publication is available in English and Spanish.

Washington developed a manual documenting its process for moving towards cultural competency entitled "Building Cultural Competence: A Blueprint for Action".

Michigan developed a brochure entitled " From Words to Action: Notes on Serving A Culturally Diverse Population" which provides guidance on ways to encourage active involvement of parents and other members of culturally diverse communities in the organization's programs and other activities.

New Mexico wrote articles for the Children's Medical Services (CMS) Advisor, a state newsletter published jointly by the staff and CMS Medical Advisory Committee.

Summary from the States in the Consortium

The consortium states have made tremendous strides in moving their organizations and staff towards cultural competency. The "lessons learned" is their way of sharing with other agencies the roadblocks and successes they encountered in their quest.

Reflecting of the past three years, consortium state representatives made a series of recommendations based on their experiences in implementing cultural competency initiatives:

- The definition of cultural competency should be expanded to include other types of diversity within communities and organizations. These include, but are not limited to, the following components: gender, age, socio-economic level, educational level, sexual orientation, rural/urban residence, and religion.

- The cultural diversity and competency initiative should encompass all maternal and child health programs (rather than targeted for children with special health needs) and all programs within the Department of Health.

- Technical assistance should be targeted on the developmental stage of cultural competency within the organization.

- More communication, networking and sharing of ideas and resources should take place among states working to incorporate cultural competency into their programs.

- A regional roster of consultants would facilitate the process of locating qualified and skilled trainers and facilitators.

- Better collaboration is needed at the state and local levels. Increased coordination among organizations and programs that serve similar populations would better meet the needs of clients and communities.

This chapter highlighted some lessons learned in order to guide other organizations in their cultural competency initiatives. It is hoped that those organizations desiring additional information will take the opportunity to contact the states' representatives to the consortium and talk in greater depth about their cultural competency efforts (see list in Appendix A).

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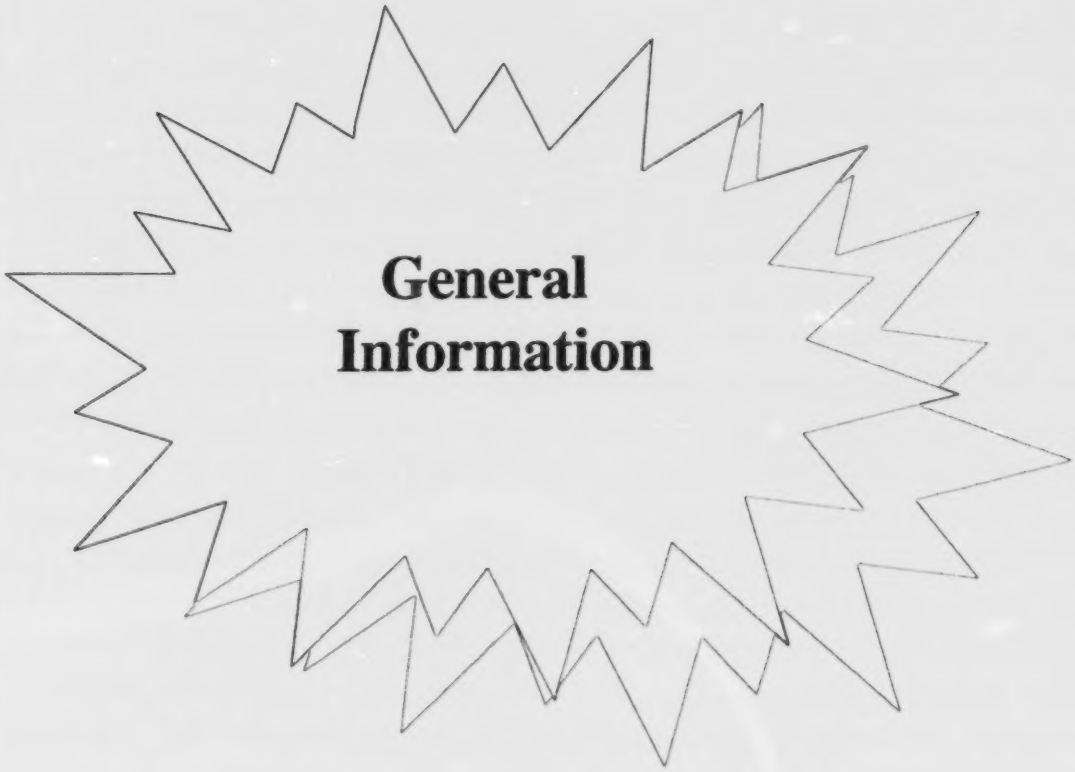
1. The Diversity Factor, Winter 1995, Volume 3, Number 2

2. Plan for Enhancing and Integrating Cultural Diversity in Agency Operations, 1994, page 6

APPENDIX A



The National MCH Resource Center on Cultural Competency was housed in the Texas Department of Health. When the grant period ended, the staff became the Texas Department of Health (TDH) Resource Center on Cultural Competency. You may contact the Texas Center by calling or writing:

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* *These representatives were interviewed for input on state's activities and the Center's involvement for inclusion in this publication*

** *Nevada participated with the consortium from October, 1994*

*** *Pennsylvania joined the consortium in June, 1994*

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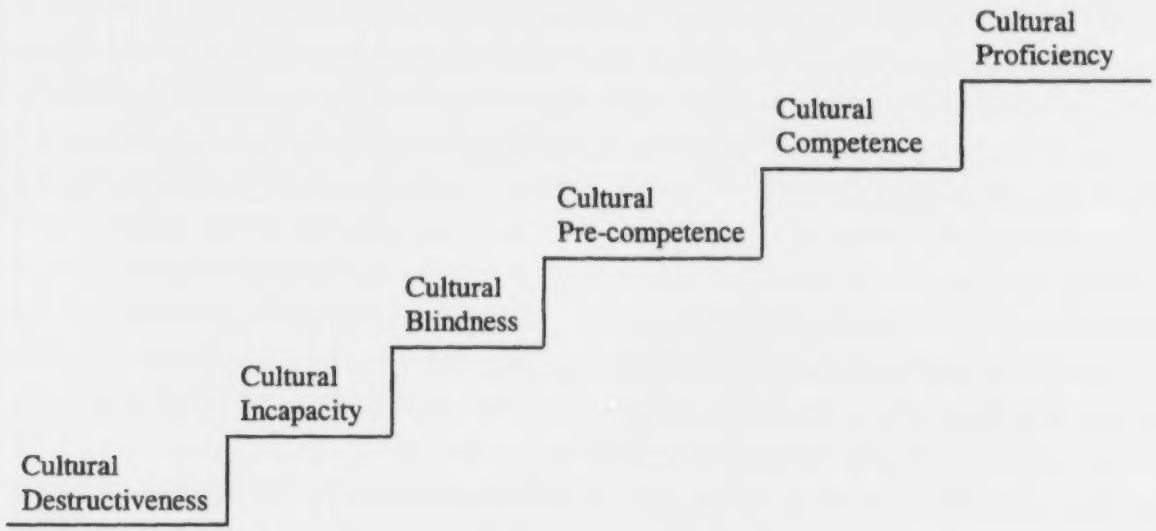
APPENDIX B

Cultural Competence Continuum



Cultural Destructiveness

The most negative end of the continuum is represented by attitudes, policies, and practices that are destructive to cultures and consequently to the individuals within the culture. The most extreme examples of this orientation are programs/agencies/institutions that actively participate in cultural genocide---the purposeful destruction of a culture. For example, the Exclusion Laws of 1885-1965 (Hune, 1977) prohibited Asians from bringing spouses to this country, immigration quotas restricted their migration, and laws denied basic human rights on the state and federal level. Another example of cultural genocide is the systematically attempted destruction of Native American culture by the very services set up to "help" Indians, i.e., boarding schools (Wilkinson, 1980). Equally destructive is the process of dehumanizing or subhumanizing minority clients. Historically, some agencies have been actively involved in services that have denied people of color access to their natural helpers or healers, removed children of color from their families on the basis of race, or purposely risked the well-being of minority individuals in social or medical experiments without their knowledge or consent.

One area peculiar to Native Americans is the Indian Child Welfare Act. This act is an example of a legislative response to culturally-destructive practices. The Act sets up requirements for states regarding placement procedures for Indian children. These requirements are designed to protect children's rights to their heritage and to protect children as the most valuable resource of Indian people. States must deal with Indian tribes on a government-to-government basis.

While not many examples of cultural destructiveness are currently seen in the mental health system, it provides a reference point for understanding the various possible responses to minority communities. A system which adheres to this extreme assumes that one race is superior and should eradicate "lesser" cultures because of their perceived subhuman position. Bigotry coupled with vast power differentials allows the dominant group to disenfranchise, control, exploit, or systematically destroy the minority population.

Cultural Incapacity

The next position of the continuum is one at which the system or agencies do not intentionally seek to be culturally destructive but rather lack the capacity to help minority clients or communities. The system remains extremely biased, believes in the racial superiority of the dominant group, and assumes a paternal position toward "lesser" races. These agencies may disproportionately apply resources, discriminate against people of color on the basis of whether they "know their place," and believe in the supremacy of dominant culture helpers. Such agencies may support segregation as a desirable policy. They may act as agents of oppression by enforcing racist policies and maintaining stereotypes. Such agencies are often characterized by ignorance and an unrealistic fear of people of color. The characteristics of cultural incapacity include: discriminatory hiring practices, subtle messages to people of color that they are not valued or welcome, and generally lower expectations of minority clients.

Cultural Blindness

At the midpoint on the continuum, the system and its agencies provide services with the express philosophy of being unbiased. They function with the belief that color or culture make no difference and that all people are the same. Culturally-blind agencies are characterized by the belief that helping approaches traditionally used by the dominant culture are universally applicable; if the system worked as it should, all people--regardless of race or culture--would be served with equal effectiveness. This view reflects a well-intended liberal philosophy; however, the consequences of such a belief are to make services so ethnocentric as to render them virtually useless to all but the most assimilated people of color.

Such services ignore cultural strengths, encourage assimilation, and blame the victim for their problems. Members of minority communities are viewed from the cultural deprivation model which asserts that problems are the result of inadequate cultural resources. Outcome is usually measured by how closely the client approximates a middle class, non-minority existence. Institutional racism restricts minority access to professional training, staff positions, and services.

Eligibility for services is often ethnocentric. For example, foster care licensing standards in many states restrict licensure of extended family systems occupying one home. These agencies may participate in special projects with minority populations when monies are specifically available or with the intent of "rescuing" people of color. Unfortunately, such minority projects are often conducted without community guidance and are the first casualties when funds run short. These agencies occasionally hire minority staff, but tend to be motivated more by their own needs than by an understanding of the needs of the client population. Such hiring drains valuable resources from the minority community.

Culturally-blind agencies suffer from a deficit of information and often lack the avenues through which they can obtain needed information. While these agencies often view themselves as unbiased and responsive to minority needs, their ethnocentrism is reflected in attitude, policy, and practice.

■■■ Cultural Pre-competence

As agencies move toward the positive end of the scale, they reach a position called cultural pre-competence. This term was chosen because it implies movement. The pre-competent agency realizes its weakness in serving minorities and attempts to improve some aspect of their services to a specific population. Such agencies try experiments, hire minority staff, explore how to reach people of color in their service area, initiate training for their workers on cultural sensitivity, enter into needs assessments concerning minority communities, and recruit minority individuals for their boards of directors or advisory committees. Pre-competent agencies are characterized by the desire to deliver quality services and commitment to civil rights. They respond to minority communities' cry for improved services by asking, "what can we do?" One danger at this level is a false sense of accomplishment or of failure that prevents the agency from moving forward along the continuum. An agency may believe that the accomplishment of one goal or activity fulfills their obligation to minority communities or they may undertake an activity that fails and are therefore reluctant to try again.

Another danger is tokenism. Agencies sometimes hire one or more (usually assimilated) minority workers and feel they are then equipped to meet the need. While hiring minority staff is very important, it is no guarantee that services, access, or sensitivity will be improved. Because minority professionals are trained in the dominant society's frame of reference, they may only be a little more competent in cross-cultural practice than their co-workers. Minority professionals, like all other professionals, need training on the function of culture and its impact on client populations. The pre-competent agency, however, has begun the process of becoming culturally competent and often only lacks information on what is possible and how to proceed.

■■■ Cultural Competence

Culturally competent agencies are characterized by acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations to service models in order to better meet the needs of minority population. Such agencies view minority groups as distinctly different from one another and as having numerous subgroups, each with important cultural characteristics. Culturally competent agencies work to hire unbiased employees, seek advice and consultation from the minority community, and actively decide what they are and are not capable of providing to minority clients. Culturally competent agencies seek minority staff whose self-analysis of their role has left them committed to their community and capable of negotiating a bicultural world. These agencies provide support for staff to become comfortable working in cross-cultural situations. Further, culturally competent agencies understand the interplay between policy and practice, and are committed to policies that enhance services to diverse clientele.

Cultural Proficiency

The most positive end of the scale is advanced cultural competence or proficiency. This point on the continuum is characterized by holding culture in high esteem. Culturally proficient agencies seek to add to the knowledge base of culturally competent practice by conducting research, developing new therapeutic approaches based on culture, and publishing and disseminating the results of demonstration projects. Culturally proficient agencies hire staff who are specialists in culturally competent practice. Such agencies advocate for cultural competence throughout the system and for improved relations between cultures throughout society.

Cross, T.L., Bazron, B.J., Dennis, K.W., Isaacs, M.R., *Towards a Culturally Competent System of Care*. Vol. I.: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed. Washington, D.C., CASSP Technical Assistance Center, Georgetown University Child Development Center, 1989.

CULTURAL DESTRUCTIVENESS

Policy Making Level

The culturally destructive organization tends toward policies that seek to break down minority cultures. It is assumed that the dominant culture is the only viable culture. All others are regarded as lesser, primitive or inferior. Policies do not value diversity. Knowledge about cultures is based largely on negative myths.

Persons of minority cultures are restricted formally or informally from serving on or advising the governing body. Policy makers often mandate services to save or civilize individuals of minority cultures while participating in their disenfranchisement. Language differences are not tolerated. Natural helping systems are regarded as bad and are eliminated if possible. Employment practices effectively eliminate people of color from working in helping or administrative roles.

Administrative Level

The culturally destructive organization exhibits administrative procedures and infrastructure that enables the organization to break down minority cultures. It is assumed that the dominant culture is the only viable culture. All others are regarded as lesser, primitive or inferior. Neither procedures nor facilities express a value on diversity. Knowledge about cultures is based largely on negative myths.

Persons of minority cultures are restricted formally or informally from serving as or advising the administrative staff. Administrators may plan and implement services to save or civilize individuals of minority cultures while participating in their disenfranchisement. Language differences are not accepted. Natural helping systems are regarded as bad and are eliminated if possible. Employment practices effectively eliminate people of color from working in helping roles.

Service Provider Level

Direct service providers use approaches that tent to define cultural differences as pathology. People of minority cultures may be treated as objects to be civilized and saved or as inferior beings who need to be suppressed, controlled, or eliminated. Knowledge about cultures is limited to myth. and stereotype.

Persons of color are restricted formally or informally from access to services. Special service agencies, and or skills may be employed to ensure separation, and control or to force assimilation. Self determination is usually not valued. Natural helping systems are often the only available resources for help but are seen by the dominant society as pathological.

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Community Level

Community of color are victims of oppression. Individuals who do not comply with culture destroying activities of the dominant society are labeled as deviant. Communities of colors quietly resist, natural helping goes underground and people may feel powerless to have their needs met.

Diversity is not valued. Communities of color usually know their problems but have nowhere to report what they believe or know. Tension with mainstream may be high unless behavior is adjusted to fit mainstream expectations. Organization-community relations are often adversarial.

CULTURAL INCAPACITY

Policy Level

Agency policy regarding people of color is virtually non-existent. The unwritten policy is to not have policy. Minority cultures are regarded as not amendable to helping services and unworthy of resources being allocated toward their needs. Policies do not value diversity. Diversity may be regarded as a problem. Knowledge about cultures is stereotypical at best. No capacity for self-assessment exists or is desired.

Persons of color are usually not regarded as appropriate for serving on or advising the governing body. Organizations may not actively restrict their access to such roles, yet they do nothing to make it possible. Policy makers mandate services that respond directly to the needs of the dominant population, discourage outreach, and tend to blame minority communities when they do not use the agency's services. When these agencies must offer services to people of color there is a tendency to offer a lower or more restrictive level of service or to have lower outcome expectations.

Language differences may be used as a reason not to serve people of color. Natural helping systems are not acknowledged or may be used as an excuse to not serve a population on the basis that they "take care of their own." Employment practice may comply with law but no attempt is made to attract people of color into the helping or administrative workforce. People of color who do get hired tend to stay unless they are very assimilated in the dominant soc. They usually find themselves and their cultural group stereotyped, they receive lower pay than dominant culture persons, and they find few opportunities to advance.

Administrative Level

Agency plans regarding people of color are virtually non-existent. Minority cultures are regarded as not amenable to change and unworthy of resources being allocated toward their needs. Diversity may be regarded as a problem. Knowledge about cultures is stereotypical at best. No capacity for self-assessment exists or is desired.

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Persons of color are usually not regarded as appropriate for serving as or advising administrators. Organizations may not actively restrict their access to such roles but they also do nothing to make it possible. Administrators mandate services that respond directly to the needs of the dominant population, discourage outreach, and tend to blame minority community when they do not use the agency's services.

Language differences may be used as a reason not to serve people of color. Natural helping systems are not acknowledged or may be used as an excuse to not serve a population on the basis that they "take care of their own." Employment practices comply with law but no attempt is made to attract people of color into the helping or administrative workforce. People of color who do get hired tend not to stay unless they are very assimilated in the dominant society. They usually find themselves and their cultural group stereotyped, they receive lower pay than dominant culture persons and they find few opportunities to advance.

Service Provider Level

Providers view people of color as not amenable to treatment and avoid providing services when possible. When services are provided, differential treatment is the norm. Outcome expectations are often lower.

Providers have few if any cross-cultural skills and tend to deny that cultural issues are important to treatment. People of color may be regarded as problems rather than clients and the primary services rendered is referral. Knowledge about cultures is not seen as relevant to the provider and training on the subject is resisted. Providers may use mainstream theory base to justify biases and as confirmation of negative attitudes about minority groups. Providers may have unrealistic fears of clients of color.

Clients who do not speak English are often not considered as part of the service population.

Community Level

Communities of color do not attempt to access these agencies, and often actively avoid contact. Oral history labels theses services as threats to family integrity. Community may learn to manipulate the organization to get basic needs met. Communities rely on their own natural helpers even when these resources are strained.

Communities assess their own needs in order to advocate for access to rights and services. Race relations may be difficult, with periodic negative interactions. Line of community are not open.

CULTURAL BLINDNESS

Policy Level

The culturally blind organization often has policies that declare that the agency does not discriminate on the basis of race. Unwritten policy tends to be that every person should be treated equally. It is assumed that if the agency ignores culture or race and provides the same service to all clients that they will meets needs equally. Culture is not a matter of consideration in planning. Needs of minorities are not systematically studied. Cultures apart from the mainstream may be viewed stereotypically. Equality is valued but diversity may be denied. Self-assessment regarding cultural issues is not usually considered as necessary.

Persons of minority cultures may find their way into governing bodies or advisory groups but are often treated as token members. They find most reinforcement when they assimilate to the norms of the dominant society and may find themselves labeled if they raise concerns about cultural issues. Policy makers often mandate that services should be equally provided and are careful not to discriminate. Knowledge about cultures is not usually sought and no mechanism exists for its retention.

Language differences are seen as a problem to be solved through referral and or volunteer interpreters. The work of natural helpers may be accepted but "clinical" knowledge is regarded as superior. Employment practices are equal opportunity (making sure everyone has a chance) or affirmative action (taking steps to enhance access). Resistance against hiring policies from agency personnel are often the norm. Turnover rates are high for people of color and their performance is frequently rated as poor.

Administrative Level

The culturally blind organization has procedures that avoid discrimination on the basis of race. Unwritten procedures tend to assure that every person is treated equally. It is assumed that if the agency ignores culture or race and provides the same service to all clients that they will meet needs equally. Culture is not usually a matter of consideration in planning. Needs of minorities are not systematically studied. Cultures apart from the mainstream may be viewed stereotypically. Equality is valued but diversity may be denied. Self-assessment regarding cultural issues is not usually considered as necessary.

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or affirmative action (taking steps to enhance access). Resistance against hiring policies from agency personnel are often the norm. Turnover rates are high for people of color and their performance is frequently rated as poor.

CULTURAL PRE-COMPETENCE

Policy Level

Policy of these agencies begins to show the valuing of diversity. Policies may facilitate outreach, demonstration projects and/or cultural sensitivity training. Policies may mandate specific responses to specific needs of a cultural group. Policy makers realize that the organization's capacity to serve people of color needs to be enhanced. Efforts to enhance services are not guided, however, by a plan. Resources within communities of color go untapped due to lack of lines of communication. Policy makers or governing bodies may be not trust that communities of color have the capacity to guide them. Self-assessment has begun but often lacks a systematic approach.

Persons of minority cultures are encouraged to serve on advisory and or governing bodies. No plan guides this effort, however. Policy makers may mandate cultural sensitivity or awareness but often without service structure adaptions. Language differences are viewed as a management issue. Bilingual staff or contract interpreters may be recruited. Natural helpers play a role in developing sensitivity and awareness but are not seen as full partners in the helping process. Employment practices remain very much the same but agencies begin to look for bilingual, bicultural staff persons. Knowledge about cultures is desired but no seen as very accessible.

Administrative Level

The infrastructure of these agencies begin to show valuing of diversity. Procedures may facilitate outreach, demonstration projects, and or cultural sensitivity training. Procedures may mandate specific responses to specific needs of a cultural group. Administrators realize that the organization's capacity to serve people of color needs to be enhanced. Efforts to enhance services are not guided by a plan, however. Resources within communities of color go untapped due to lack of lines of communication. Administrators may not trust that communities of color have the capacity to guide them. Self-assessment has begun but often lacks a systematic approach.

Persons of minority cultures are encouraged to serve as consultants. Administrators may mandate cultural sensitivity or awareness training but often without service structure adaptations. Language differences are viewed as a management issue. Bilingual staff or contract interpreters may be recruited. Natural helpers play a role in developing sensitivity and awareness but are not seen a full partners in the helping process. Employment practices remain very much the same but agencies begin to look for bilingual bicultural staff persons. Knowledge about cultures is desired but not seen as very accessible.

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Service Provider Level

The direct service provider has beginning awareness that culture makes a difference. The worker at this point on the continuum is uncomfortable with lack of success for clients of color. They desire to do a better job but are unsure of how to proceed. Providers may attend cultural awareness or cultural sensitivity trainings. They begin to experiment with new helping approaches. Providers may become over identified with communities of color at this stage and adopt dress, mannerisms or slang. Others may use new (but limited) knowledge to form new stereotypes about people of color. A process of self examination begins to contribute to professional growth and an expanded knowledge of the persons own culture. Providers begin to ask the role of culture in all human behavior.

Community Level

Communities respond to these agencies with optimistic caution. Tension may grow as people of color are invited to advise and inform the organization but can become productive if managed well. Lines of communication may become blurred and organization may become embroiled in conflicts about who speaks for a specific community or about with culture diversity. Community are usually willing to keep communicating as long as progress is being made.

CULTURAL COMPETENCE

Policy Level

Policies express a valuing of diversity. Cultural differences are acknowledged and accepted as important to service delivery effectiveness. Empowerment of people of color is embraced. All cultures are seen as viable with the capacity to generate effective solutions for human problems.

Persons of color are an integral part of the governing, policy making process. A plan for obtaining and keeping a diverse policy making body is written and communicated well to the community. Policy makers mandate culturally competent service delivery and adjust service delivery to be responsive to diverse needs. Information about people of color and their needs is accessible and systematically included in planning. Language differences are managed via institutionalized capacity. Natural helpers may be regarded as consultants or as liaisons with communities of color. Employment practices include job description requiring the capacity to work effectively cross-culturally and performance evaluations review this capacity.

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Administrative Level

Procedures, facility and management express a valuing of diversity. Cultural differences are acknowledged and accepted as important to service delivery effectiveness. Empowerment of people of color is embraced. All cultures are seen as viable, with the capacity to generate effective solutions for human problems.

Persons of color are an integral part of the administrative team. A plan for obtaining and keeping a diverse management team is written down. Administrators assure, to the extent possible, culturally competent service delivery and adjust service delivery to be responsive to diverse needs. Information about people of color and their needs is accessible or institutionalized and systematically included in planning. Language differences are managed via an institutionalized capacity. Natural helpers may be regarded as consultants or as liaisons with communities of color. Employment practices include job description requiring the capacity to work effectively cross-culturally and performance review this capacity.

Service Provider Level

The service provider is aware of and accepting of cultural differences. Cultures are seen from a more balanced view of having both strengths and weaknesses. Awareness of the cultural values and norms that shape the providers professional practice is understood. Personal history regarding feeling about difference or various cultural groups is under continual review. Steps toward personal and professional growth are taken.

Cultural knowledge is added routinely and avenues to information are used as needed. Knowledge about unique issues of mental health and service delivery is secured. Consultation with natural helpers and/or professionals of color are an integral part of practice. The provider uses a variety of cross-cultural practice skills, such as cross-cultural interviewing techniques, as standard parts of their practice. Interventions are designed to meet the need as defined by the client.

Community Level

Communities of color develop a sense of ownership of agencies they have a key role in leading. Community leaders become advocates for the programs of the agency. Information about the community is provided to the organization freely and planning suggestions may include joint ventures, community development or other empowering activity. Process becomes as important as outcome and the dynamics of difference are understood and managed.

CULTURAL PROFICIENCY

Policy Making Level

Policy makers regard culture highly and view the agency as a vehicle for community empowerment. Policies promote diversity as a desirable context for services and community life. Each culture is regarded as having unique qualities to offer the whole society.

Persons of minority cultures share policy making roles. Policy makers mandate that the organization test the boundaries of possible service approaches, including use of natural helpers. Language is used as a means to enhance understanding of the world. Employment practices promote leadership by searching out talent for cross-cultural practices and fostering it.

Administrative Level

Administrators regard culture highly and view the agency as a vehicle for community empowerment. Procedures and facilities promote diversity as a desirable contest for service and community life. Each culture is regarded as having unique qualities to offer the whole society.

Persons of minority cultures share administrative roles. Administrators test the boundaries of possible service approachers, including use of natural helpers. Employment practices promote leadership by searching out talent for cross-cultural practice and fostering it.

Service Provider Level

The provider assists in the development and testing of new practice techniques. They serve as teachers, mentors or advocates for cross-cultural practice. Work with natural helpers is standards and health and healing are defined by the client population. The service provider uses advanced skills and may consult with other agencies on cross-cultural issues. Diversity is promoted as a desirable social environment. Race relations are influenced positively through active efforts. The practitioner may contribute to the field through writing, publishing or supervising.

Community Level

Communities of color contribute new understanding of human behavior and helping approaches. Communities participate in program design, testing and evaluation. New approaches to problem resolution are generated and adopted by the mainstream agency. New means of enhancing intercultural relations are introduced. New knowledge is contributed to the field.

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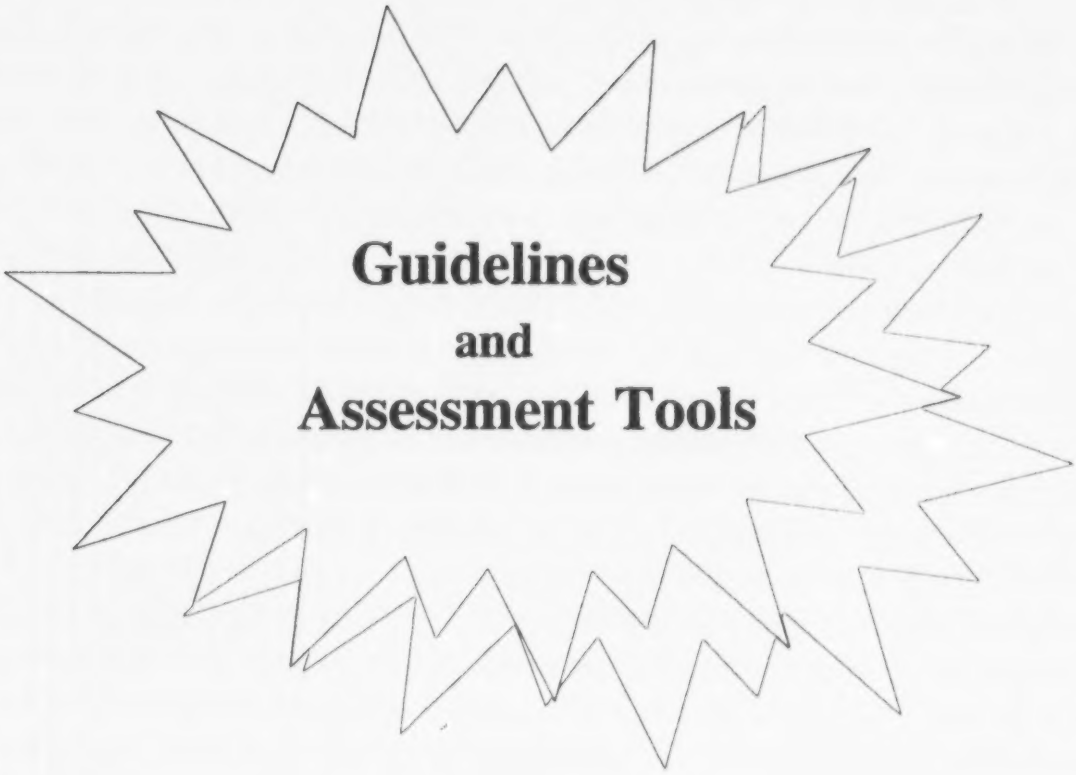
APPENDIX C



GUIDELINES FOR MEASURING CULTURAL COMPETENCE IN APPLICATION AND CONTRACT REVIEWS AND PROGRAM MANAGEMENT OF CURRENTLY FUNDED PROGRAMS

PREAMBLE

Recognizing that there are not specific parameters along which program staff can follow to measure the cultural criteria of a program, the following guidelines are proposed.

Cultural competence refers to a set of congruent behaviors, languages, belief systems, attitudes, and polices that reflect the capacity and capability of an individual, agency, or services system to respond appropriately and effectively to the cultural history, norms, values, and needs of targeted populations and communities in the conduct of prevention activities. The targeted population may include any group that has an established set of norms, values, beliefs, and practices that define the identity of that group.

The cultural competence guidelines are intended to stimulate an interactive and ongoing process of developing and continuing to maintain the capacity for addressing the cultural issues within a community from a prevention perspective. They attempt to objectively assess the cultural competence of an individual, agency, or service system along a continuum of overall cultural adequacy thus avoiding the tendency to view cultural competence as an absolute and finite measurement.

GUIDELINES

1. Is there a track record and recent history of programmatic involvement with the cultural target population or community to be addressed in the grant application? What have been the experiences of the applicant organization or individuals?

2. Have the staff of the program received clear and specific training in the cultural pattern of the community proposed for services? Is there clear evidence that the staff have been effective in providing services within that community? Are there staff members proposed for the project for leadership and direct service roles due to their personal membership, training, or experience in the cultural community? Are designated staff ready and prepared to train and translate community cultural patterns to the remaining staff?

3. Are there working mechanisms in place for members of the cultural group to be served to influence the pattern of planned interventions? Is there an advisory council or organizational board of directors of the organization (with legitimate and working agreements) for decision-making to affect the course and direction of the proposed program? Are sufficient members of the cultural group represented on the advisory council and organizational board of directors?

4. Is there evidence that the cultural community at large, not just a token few, has had a significant role in the development of the proposed project? Is there evidence that the needs of the community have been assessed, and alternative strategies proposed and considered to address the defined issues of concern? Is there evidence that there has been opportunity for contributions or changes to be made to the policies and procedures as a result of community meetings?

5. If multi-linguistic competency is important in the cultural community to be served, does the organization to provide services have this resource among its staff (proposed professional and non-professional) sufficient at all levels of service delivery or the proposed program? Are there plans for obtaining such resources?

6. If curricula, media materials, PSA's training guides, and other materials are to be employed in the planned program, is there adequate pre-testing to insure that these materials are culturally appropriate or will be made culturally consistent with the community to be served (using community representatives as one method of validation of cultural appropriateness)?

7. Have the evaluation instruments for the project been developed for the culturally specific group or groups targeted for interventions and subsequent assessment? If the instruments have been imported from another project using a different cultural group, has there been an adequate evaluation and/or revision of the instruments so the instruments are now demonstrably culturally specific to the target group(s) planned? Are evaluators sensitized to the culture the program is serving?

8. Are there other objective indicators in the proposal of cultural competence? Does the agency have a history of projects that include the cultural community proposed for service? Is there a presence of a narrative description in the proposal to assure staff cultural competence by experience or training or membership with the group proposed for prevention services? Is there evidence the organization includes the community in its planning, program development and post service assessments with services given to the community and from within the community? Is there objective evidence in the application that the applicant is knowledgeable of cultural aspects of the community that will be important to the success or failure of the prevention effort?

WASHINGTON STATE DEPARTMENT OF HEALTH
CULTURAL COMPETENCY CHECKLIST TO ACCOMPANY GRANT PROPOSALS

Purpose: In writing grants, applicants are asked to describe how their services are culturally competent. Often the responses are very limited, perhaps mentioning the availability of translated materials and the addition of a bilingual outreach worker. Although applicant agencies intend to provide culturally competent services, they are often unaware of what that means.

This checklist does not replace a thorough agency self-assessment, rather it is a way for an agency to begin asking questions on what it means to be culturally competent. The checklist was developed from the self-assessment resources listed below.

1. The agency collects and analyzes culturally specific data.

2. The agency conducts needs assessments involving members of the cultural communities served, including the use of focus groups to develop and evaluate programs and services.

3. The agency has a clear process for evaluating the short and long term impact of its programs and policies on culturally diverse clients and communities.

4. The agency consults with organizations or individuals who represent cultural groups in the community served before finalizing programs and policies that may have a cultural impact.

5. The agency considers cultural factors such as language, race, ethnicity, customs, family structure, and community dynamics in developing its policies and services.

6. Administrators and board of directors include all levels of staff, including paraprofessionals, in the decision-making process, to the maximum extent possible.

7. The agency provides all staff, including managers, with cultural competency training.

8. Agency actively recruits a diverse work force.

9. Job descriptions and performance evaluations include an employee's understanding of and sensitivity to serving diverse populations.

10. The agency staffing includes managers and key administrators from diverse cultural backgrounds.

11. Agency staff includes natural healers or other non-credentialed cultural group members.

12. The agency makes available bilingual services when needed.

13. Agency staff develop case plans and conduct client assessments in a manner that is culturally specific and involves the client.

Self-Assessment Resources

Cultural Competence Self-Assessment Instrument, Child Welfare League of America, 440 First Street, N.W., Suite 310, Washington, D.C. 20001-2085, (202) 638-2952. Publication ISBN #0-87868-506-5

Cultural Competence Self-Assessment Questionnaire, James L. Mason, The Portland Research and Training Center on Family Support and Children's Mental Health, Graduate School of Social Work, Portland State University, P.O. Box 751, Portland, Oregon 97207

Project Turning Point, The Children's Alliance, 172 20th Avenue, Seattle, Washington 98122, (206) 325-6291.

Cultural Competency Checklist, Institute for Child Health Policy, University of Florida, and the National MCH Resource Center on Cultural Competency, 1100 West 49th Street, Austin, Texas 78756. Contact: Don Lawson, (512) 458-7658.

Service Delivery Assessment

Please mark the appropriate box that best represents your organization's service delivery

		Yes	No
1.	Do you provide interpreter services for your clients?	☐	☐
2.	Do you provide culturally specific, translated material for your clients?	☐	☐
3.	Do you provide special outreach programs for cultural groups?	☐	☐
4.	Do you provide any type of transportation for your clients?	☐	☐
5.	Do you provide access, other than regular 8 to 5 working hours?	☐	☐
6.	Do you market health prevention messages to cultural groups?	☐	☐
7.	Are people from cultural groups depicted in poster and brochures?	☐	☐
8.	Do staff members belong to the same cultural group they serve?	☐	☐
9.	Does staff have close ties with the community they serve?	☐	☐
10.	Does staff know the culture and health status of the cultural groups they serve?	☐	☐
11.	Is staff accepted by the cultural groups they serve?	☐	☐
12.	Is there in-service training on cultural diversity for staff?	☐	☐
13.	Is there in-service training on cultural health barriers for staff?	☐	☐
14.	Has staff been trained to work cross-culturally?	☐	☐
15.	Are culturally aware staff members placed in agency points of entry?	☐	☐
16.	Do you accept and make referrals to and from cultural specific alternatives?	☐	☐
17.	Do you use culture specific assessment tools for diagnosis and treatment?	☐	☐
18.	Do service/management plans integrate the individual's traditional beliefs and practices?	☐	☐
19.	Do you use culture specific treatment approaches?	☐	☐

Developed by the National MCH Resource Center on Cultural Competency in collaboration with the Washington State Department of Health in January, 1995.

TRAINING NEEDS ASSESSMENT FORM

Please check the appropriate areas that would be beneficial to you and your staff:

1. Needs Assessment of Staff Training in Cultural Competency

____ Assessment of organizational structure for cultural competency

____ How to incorporate cultural competency assessment into Title V block grant needs assessment

____ Assessment of identified staff - organizational, contractual, local health department, and/or private provider

2. Policy, Procedures, and Committee Structures

____ How to assess your policy and procedures as they relate to cultural competency

____ How to incorporate cultural competency principles into policy and procedures

____ How to include diverse cultures in organizational structures for planning and evaluating services at state and local levels

3. Staff Training

____ Resource identification

____ Develop local resources

____ Relating organizational/staff training to the cultural competency

4. Demonstration Site for Cultural Competency Programs

____ Provision of delivery models for culturally competent services

____ Coordinating existing models of cultural competency within states

Developed by the National MCH Resource Center on Cultural Competency for Children with Special Health Care Needs

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STAFFING ASSESSMENT

Demographics*

What is the composition of your agency/program staff?

Number of Asian/Pacific Islanders	_____
Number of Blacks	_____
Number of Hispanics/Latinos	_____
Number of Native Americans	_____
Number of Whites	_____
Others	_____
TOTAL	_____

What is the racial composition of staff in the following job categories?

Number of administrative	_____	% minority	_____
Number of professionals	_____	% minority	_____
Number of support staff	_____	% minority	_____

Hiring/Promotion

Does your agency advertise job postings in minority media such as Black/Hispanic newspapers?	☐Yes	☐ No
Does your agency hire bilingual staff?	☐Yes	☐ No
Does your agency offer special developmental training to minority employees?	☐Yes	☐ No
Does your agency offer any mentoring programs for minority employees?	☐Yes	☐ No
Does your agency have a career ladder for minorities?	☐Yes	☐ No

Inclusion

Does your agency have minority representation on...

Executive committees	☐ None	☐ Some	☐ Many
Policy/decision making committees	☐ None	☐ Some	☐ Many
Health care/prevention planning committees	☐ None	☐ Some	☐ Many

* State agencies can obtain much of this information from Equal Employment Opportunity form #4.

CULTURAL COMPETENCE ASSESSMENT FOR

(Title of Organization or Work Center)

The following questions are being asked for research purposes only and will not be used to identify you. Please circle the appropriate number or fill in where requested.

Demographic Information for Administration and Staff

A. Sex: 1. Female 2. Male

B. Race/Ethnic Origin:

1. Asian/Pacific Islander
2. Black/African American
3. Caucasian
4. Hispanic or Latin American
5. Native American / American Indian
6. Other (please specify)_____

C. Age: 1. 18-21_____ 2. 22-35_____ 3. 36-45_____
4. 46-55_____ 5. 56-65_____ 6. over 65_____

D. Marital Status:

1. Married or marriage-like living arrangement
2. Single
3. Divorced
4. Separated
5. Widowed

E. Highest level of education:

1. Some high school or less
2. High school diploma or GED
3. Business or trade school
4. Some college
5. College degree
6. Some graduate school
7. Graduate degree

F. Your position:

Administration _____
Staff _____
Clerical _____
Custodial _____
Dietary _____

How long have you held this position? _____

Personal Involvement

G. Do you attend cultural, ritual, or ceremonial functions sponsored or presented by specific cultural groups?

1. Not at all 2. Seldom 3. Sometimes 4. Often

If you circled 2, 3, or 4, please specify cultural group: _____

H. Do you interact with people of various cultures within your service area?

1. Not at all 2.. Seldom 3. Sometimes 4. Often

If you circled 2, 3, or 4, please specify cultural group: _____

Do you consider these interactions: 1. Professional 2. Social 3. Both

I. If you speak any language other than English, please list.

1._____ 2._____ 3._____

J. Do you purchase any goods or services from businessmen or businesswomen of various cultures?

1. Not at all 2. Seldom 3. Sometimes 4. Often

If you circled 2, 3, or 4, please specify cultural group: _____

K. Do any of your recreational or leisure pursuits occur within communities of various cultures?

1. Not at all 2. Seldom 3. Sometimes 4. Often

If you circled 2, 3, or 4, please specify cultural group: _____

L. Do you feel unsafe in communities of various cultures?

1. Not at all 2. Seldom 3. Sometimes 4. Often

If you circled 2, 3, or 4, please specify cultural group: _____

M. Describe how your personal involvement with groups from various cultures has impacted your work. _____

_____

Staffing

The following questions are being asked for research purposes only and will not be used to identify you. Please circle the appropriate number or fill in where requested.

1. Are there people of different cultures on the staff? yes_____ no_____

2. Is training provided that helps the staff work with people of different cultures?
   yes_____ no_____

3. Are people of different cultures actively recruited for staff positions?
   yes_____ no_____

4. Does staff routinely discuss issues and concerns relating to working with people of various cultures? yes_____ no_____

5. Does administration routinely discuss their comforts and discomforts of working with consumers and professionals of different cultures? yes_____ no_____

6. Is there ethnic group representation on your:

   - board of directors yes_____ no_____. If yes, what percentage _____

   - professional/community consultants yes_____ no_____

   - policy-making bodies yes_____ no_____.

7. Are translators and interpreters hired to help communication with the various cultures being served? yes_____ no_____

8. Are there policies and procedures that promote cultural competency?
   yes_____ no_____

9. From your perspective, what improvements could be made in staffing and/or staff training to facilitate working with various cultural groups?

   _____

   _____

Organizational Policies and Procedures

The following questions are being asked for research purposes only and will not be used to identify you. Please circle the appropriate number or fill in where requested.

1. In general, how well are policies communicated to service providers from administration?

   1. Not at all 2. Barely 3. Fairly Well 4. Very Well

2. Is information on the ethnicity or culture of patients specifically recorded in TCID's management information system?

   yes_____ no_____ don't know _____

3. Are you aware of any existing policies or procedures that reflects the provision of culturally competent care? yes_____ no_____. If answered yes, please specify:_____

   _____

   _____.

CULTURAL COMPETENCE ASSESSMENT FOR

(Title of Organization or Work Center)

The following questions are being asked for research purposes only and will not be used to identify you. Please circle/check the appropriate number or fill in where requested.

Demographic Information for Patients

A. Sex: 1. Female 2. Male

B. Race/Ethnic Origin:

1. Asian/Pacific Islander
2. Black/African American
3. Caucasian
4. Hispanic or Latin American
5. Native American / American Indian
6. Other (please specify)_____

C. Age: 1. 18-21 _____ 2. 22-35 _____ 3. 36-45 _____
4. 46-55 _____ 5. 56-65 _____ 6. over 65 _____

D. Marital Status:

1. Married or marriage-like living arrangement
2. Single
3. Divorced
4. Separated
5. Widowed

E. Highest level of education:

1. Some high school or less
2. High school diploma or GED
3. Business or trade school
4. Some college
5. College degree
6. Some graduate school
7. Graduate degree

F. Before being admitted to the hospital, where did you live? _____

Personal Involvement

G. Do you attend cultural, ritual, or ceremonial functions sponsored or presented by specific cultural groups?

1. Not at all 2. Seldom 3. Sometimes 4. Often

If you circled 2, 3, or 4, please specify cultural group: _____

H. Do you interact with people of various cultures within your service area?

1. Not at all 2.. Seldom 3. Sometimes 4. Often

If you circled 2, 3, or 4, please specify cultural group:_____

Do you consider these interactions: 1. Professional 2. Social 3. Both

I. If you speak any language other than English, please list.

1._____ 2._____ 3._____

J. Do you purchase any goods or services from businessmen or businesswomen of various cultures?

1. Not at all 2. Seldom 3. Sometimes 4. Often

If you circled 2, 3, or 4, please specify cultural group:_____

K. Do any of your recreational or leisure pursuits occur within communities of various cultures?

1. Not at all 2. Seldom 3. Sometimes 4. Often

If you circled 2, 3, or 4, please specify cultural group:_____

L. Do you feel unsafe in communities of various cultures?

1. Not at all 2. Seldom 3. Sometimes 4. Often

If you circled 2, 3, or 4, please specify cultural group: _____

YOUR EXPERIENCE:

M. Upon arrival, did you and your family members feel welcome?

yes_____ no_____ don't Know_____

If you answered yes, please state what made you feel welcome.

_____

_____

N. During your admission, were there:

sufficient seats in the waiting area to accommodate you and your accompanying family members; yes_____ no_____

staff members to greet and appropriately assist you; yes_____ no_____

members of the staff that belong to the same race/ethnic group as you? yes_____ no_____.

O. Were the forms you had to complete easy to understand? yes_____ no_____.
If you answered no to the above question, was there help available if the forms were difficult to understand. yes_____ no_____

P. The forms that you needed to complete were written in a language that you understood? yes____ no____.

If you answered no, were there translators or interpreters to assist you? yes____ no____

Q. Did you have difficulties finding your way around? yes_____ no_____

If you answered yes, please state the difficulties:_____

_____

R. Did you notice whether or not there were signs that provided directions to various places? yes_____ no_____

If you answered yes, were the signs written in a language that you understood?
yes_____ no_____

S. Did you find reading materials in the offices and waiting rooms that reflected some aspect of your culture? yes_____ no_____

T. If you are not on a special diet because of your illness, did you find the menu to include food from your culture? yes_____ no_____

U. Were you addressed or talked to in a manner that was acceptable to you?
yes_____ no_____

V. Were you asked by any staff member how you would like to be addressed?
yes_____ no_____

W. Were you ever asked by any staff member if you had spiritual or religious practices that needed to be included in your treatment? yes_____ no_____

X. Were you asked by any staff member about your beliefs and practices concerning your health care? yes_____ no_____

If you answered yes to the above, were your beliefs and practices incorporated into your treatment plan.yes_____ no_____

Y. Do you believe that the staff included your culture, beliefs, and living practices into the treatment that you are now receiving? yes_____ no_____

If you answered no to the above, please state what you feel the staff could have done to include your culture, beliefs, and living practices into your treatment plan.

_____

_____

CULTURAL COMPETENCE ASSESSMENT FOR

(Title of Organization or Work Center)

The following questions are being asked for research purposes only and will not be used to identify you. Please circle/check the appropriate number or fill in where requested.

Demographic Information for Observers

A. Sex: 1. Female 2. Male

B. Race/Ethnic Origin:

1. Asian/Pacific Islander
2. Black/African American
3. Caucasian
4. Hispanic or Latin American
5. Native American / American Indian
6. Other (please specify)_____

C. Age: 1. 18-21_____ 2. 22-35_____ 3. 36-45_____
4. 46-55_____ 5. 56-65_____ 6. over 65_____

D. Marital Status:

1. Married or marriage-like living arrangement
2. Single
3. Divorced
4. Separated
5. Widowed

E. Highest level of education:

1. Some high school or less
2. High school diploma or GED
3. Business or trade school
4. Some college
5. College degree
6. Some graduate school
7. Graduate degree

F. Occupation :_____

Personal Involvement

G. Do you attend cultural, ritual, or ceremonial functions sponsored or presented by specific cultural groups?

1. Not at all 2. Seldom 3. Sometimes 4. Often

If you circled 2, 3, or 4, please specify cultural group: _____

H. Do you interact with people of various cultures within your service area?

1. Not at all 2.. Seldom 3. Sometimes 4. Often

If you circled 2, 3, or 4, please specify cultural group:_____

Do you consider these interactions: 1. Professional 2. Social 3. Both

I. If you speak any language other than English, please list.

1._____ 2._____ 3._____

J. Do you purchase any goods or services from businessmen or businesswomen of various cultures?

1. Not at all 2. Seldom 3. Sometimes 4. Often

If you circled 2, 3, or 4, please specify cultural group:_____

K. Do any of your recreational or leisure pursuits occur within communities of various cultures?

1. Not at all 2. Seldom 3. Sometimes 4. Often

If you circled 2, 3, or 4, please specify cultural group:_____

L. Do you feel unsafe in communities of various cultures?

1. Not at all 2. Seldom 3. Sometimes 4. Often

If you circled 2, 3, or 4, please specify cultural group:_____

M. Describe how your personal involvement with groups from various cultures has impacted your work. _____

_____

Survey

1. Did you feel welcome by the staff/management of this clinic? yes ____ no ____

2. Were the staff members you had contact with friendly and open? yes ____ no ____

3. Did the staff include people of various cultures? yes ____ no ____

   If you answered yes, 1) what cultures_____

   2) types of positions held (if known)_____

4. Did the pictures on the walls represent people of various cultures? yes ____ no ___

   If you answered yes, what cultures _____

5. Was the reading material available in waiting rooms and offices sensitive to/representative of various cultures? yes ____ no ____

   If you answered yes, what cultures _____

6. Was the reading material available written in languages other than English? yes ___ no____

   If you answered "yes", was most of this material in English? yes ____ no____

7. Were there signs written in languages other than English? yes ____ no ____.

   If you answered "yes", were there enough signs for patients who do not speak English to find their way around the hospital? yes ____ no ____

8. Were the forms given to the patients written only in English? yes _____ no _____.

   If you answered "yes", were forms written in languages other than English easily available? yes ____ no ____

9. Were the religious needs of various cultures met? yes ____ no ____

10. Did you observe any menus that were appropriate for the needs of various cultures? yes ____ no ____

CULTURAL COMPETENCY CHECKLIST

I. GENERAL INFORMATION

Please ✔ the statement(s) that best describe your organization.

Policies are:

____ All created at state level
____ Some created at state level
____ Few or none created at state level

Procedures are:

____ All created at state level
____ Some created at state level
____ Few or none created at state level

II. DEMOGRAPHIC INFORMATION

Please indicate the percentage of individuals by the following characteristics who are served in your program compared to the percentage of individuals who reside in your state who are of the same age.

Population Characteristics

	White	Black	Hispanic	Haitian	Native American	Asian or Pacific Islander	Other
% Served by Program							
% Residing in State							

III. POLICY/PROCEDURE INFORMATION

Please ✔ the correct answer.

Individuals from cultural groups have input into the development of policies. ____ Yes ____ No

Individuals from cultural groups have input into the development of procedures. ____ Yes ____ No

If answered no, please proceed to section IV. If answered yes to either of the above questions, please complete the next section.

Please ✔the appropriate area(s) that indicates the degree of input into a particular policy/procedure area by individuals from cultural groups, and their frequency of review into the policy/procedural area.

	Level of Authority and Review				
	No Authority	**Review/Make Recommendations**	**Modify Policy/Procedure**	**Develop Policy/Procedure**	**Review Annually**
Policy procedure area					
All policies/procedures					
Eligibility policies/procedures					
Service policies/procedures					
Training policies/procedures					
Staff recruitment policies/procedures					
Provider recruitment policies/procedures					
Quality assurance policies/procedures					
General administrative policies/procedures					
Policies relating to cultural competence					

How are staff made aware of policies?

____ In-service education

____ Routing of policy to each individual staff member

____ Posting of policy in local offices

____ Other (specify):_____

IV. CASELOAD ASSIGNMENTS

Please ✔ all methods that apply.

____ Random Assignment ____ Geography ____ Cultural Background ____ Level of Care

____ Other (specify):_____

V. RECRUITMENT/PROVIDER CONSIDERATIONS

Please ✔ Yes or No for each question.

____ Yes ____ No If a position will serve culturally diverse groups, does the position description contain requirements for training and/or experience with cultural groups?

____ Yes ____ No Does your program use certain recruitment methods to hire an individual with experience serving particular cultural groups?

____ Yes ____ No Do you involve an individual(s) with a similar cultural background in selecting individuals to serve particular cultural groups?

____ Yes ____ No Do you involve individuals from various cultural backgrounds in the development of in-service training programs or educational materials related to particular cultural groups?

VI. SERVICE PROVISION

Please ✔ services that are provided by your program for each individual group.

	White	Black	Hispanic	Haitian	Native American	Asian or Pacific Islander	Other
Translation							
Educational material							
Special outreach services for cultural groups							
In-service training about cultural values							

VII. PARENT/FAMILY INVOLVEMENT

Please ✔ Yes or No to the following question.

Do you include community representatives from various cultural groups to have input in your organization? ___ Yes ___ No

If yes, please answer the following questions. If no, proceed to section VIII.

Are there clear roles and responsibilities for the community representatives concerning cultural competency issues? ___ Yes ___ No

Cultural competence responsibilities for community representatives include:

Training/skill building ___ Yes ___ No

Development of policy or procedures ___ Yes ___ No

Development of educational materials ___ Yes ___ No

Serving on advisory boards or councils ___ Yes ___ No

Quality assurance ___ Yes ___ No

Development of forms ___ Yes ___ No

Providing advice to families ___ Yes ___ No

VIII. ADDITIONAL INFORMATION

Please note any questions or concerns that you may have which were not addressed in this survey:_____

_____

_____

_____

_____

_____

Texas Department of Health, Centers for Minority Health Initiatives and Cultural Competency, 1100 West 49th Street, Austin, Texas 78756 (512) 458-7658 fax (512) 458-7713

APPENDIX D

CULTURAL COMPETENCY & DIVERSITY TRAINING AND ASSESSMENT CONSULTANTS

ARIZONA

Frank Dukepoo
National Center on Parent-Directed Family Resource Center
1625 North Prairie Way
Flagstaff, Arizona 86043
520-523-7227 Fax 520-523-7500

CALIFORNIA

Florene Poyadue
Parents Helping Parents
3041 Olcott Street
Santa Clara, California 95054-3222
408-727-5775 Fax 408-727-0182

Dorothy Yonemitsu
Southeast Asian Developmental Disabilities Prevention Program
San Diego Imperial Counties Developmental Services, Inc.
4355 Ruffin Road, Suite 205
San Diego, California 92123
619- 235-4270 Fax 619-235-9002

Eleanor W. Lynch, Ph.D.
Department of Special Education
San Diego State University
San Diego, California 92182
619-594-6630 Fax 619-594-6628

Linda Compton
Stir Fry Seminars & Training
470 Third Street
Oakland, California 94607
1-800- 370 STIR 510-419-3930
Fax 510-419-3934

DISTRICT OF COLUMBIA

Leticia Patino
Bazelon Mental Health Law
1101 Fifteenth Street NW, Suite 1212
Washington, D.C. 20005-5002
202-467-5730 Fax 202-223-0409

DISTRICT OF COLUMBIA

Ms. Rohini Anand, Training Director
National MultiCultural Institute
Training and Consulting Services
3000 Connecticut Avenue, NW, #438
Washington, DC 20008-2556
202-483-0700 Fax 202-483-5233

Mareasa Isaacs Shockley, Ph.D.
Human Service Collaborative
2262 Hall Place, NW, #204
Washington, DC 20007
609-455-4899 & 202-333-1893
Fax 202-333-8217

Mendel Denise Service
1831 Gallaudet Street, N.W. #1
Washington, D.C. 20002

GEORGIA

Justine Strickland
RAP Coordinator
Chapel Hill Training-Outreach Project
1618 Clark Lake Drive
Acworth, Georgia 30102
770-421-8306 Fax 770-421-8301

Melanie Miller
21st Century Consulting, Inc.
152 Cityline Ave., NE
Atlanta, Georgia 30308-2440
404-888-9246 Fax 404-881-9571

HAWAII

East-West Center
Institute of Culture and Communication
1777 East-West Road
Honolulu, Hawaii 96848
808-944-7666

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Claudette Renee Yanssaneh
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301-572-0200 Fax 301-572-0999

Carmen L. Vazquez
The Paradigm Group
404 New Mark Esplanade
Rockville, Maryland 20852
301-424-3675 Fax 301-424-2664

MASSACHUSSETTS

Andrea Ayvazian
Communitas, Inc.
245 main Street
Northhampton, Massachusetts 01060
413-586-3088 Fax 413-585-0688

Gloria Johnson-Powell, M.D., Director
Partnerships in Prevention
Professor of Psychiatry
Judge Baker's Children's Center
295 Longwood Avenue
Boston, Massachussetts 02115
617-232-8390 Fax 617-232-8399

MICHIGAN

Guadalupe Lara
Children's Hospital of Michigan
3901 Beaubien Blvd.
Detroit, Michigan 48201-2196
313-745-5281 Fax 313-993-7106

Gina Barclay-McLaughlin
2518 Stone Drive
Ann Arbor, Michigan 48105

NEW JERSEY

Laurie Nsiah-Jefferson
4 Upperbrook Court
Parlin, New Jersey

Dr. Sandra Lewis
National Pediatric HIV Resource Center
#15 South 19th Street
Newark, New Jersey 07107
201-268-8251 Fax 201-485-7769

NEW MEXICO

Elena Avila, R.N., M.S.N.
754 Saratoga, NE
Rio Rancho, New Mexico 87124
505-892-8918 Fax 505-892-0302

Trish Thomas
P.O. Box 1387
Lagona, New Mexico 87026
505-552-9889 Fax 505-552-6168

Randi Malach
Southwest Communication Resource, Inc.
P.O. Box 788
Bernalillo, New Mexico
505-867-3396

James E. Marshall. Ph.D.
12501 Conejo Road, NE
Albuquerque, New Mexico 87123
505-271-9754

NEW YORK

Michelle van Ryn, Ph.D., M.P.H.
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518-442-4055 Fax 518-442-4193

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NORTH CAROLINA

Elizabeth Randall-David, Ph.D.
1019 West Markham Avenue
Durham, North Carolina 27701
919-687-2765 Fax 919-687-4369

OREGON

Intercultural Communication Institute
8835 SW Canyon Lane, #238
Portland, Oregon 97225
503-297-4622

Elias Daniel Duarte
Duarte & Associates
9531 SW Siletz Drive
Tualatin, Oregon 97062
503-692-9259 Fax 503-691-2223

Terry Cross
Northwest Indian Child Welfare Institute
Portland State University
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Portland, Oregon 97207
503-222-4044 Fax 503-222-4007

James Mason
Regional Research Institute
Portland State University
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Portland, Oregon 97207
503-725-4055 Fax 503-725-4180

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503-234-1012

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Portland, Oregon 97230-0990
503-244-6111 Fax 503-254-1718

TEXAS

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Center for Health Policy Development, Inc.
Training & Technical Assistance
Coordinator
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San Antonio, Texas 78238-4519
1-800-847-7212 210-520-8020
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Sharon Buford, Project Director
City of Dallas
Environmental and Health Services Center
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Dallas, Texas 75201
214-670-3863

Artie Onayemi, RN, Me.D.
Citizens for Better Health, dba CBH
Community Outreach Center
1320 Main Street, #211
Houston, Texas 77002
713-671-3890

Richard Lewis, Jr., Ph.D.
Roundtop Consulting Associates
11106 Forest Lagoon
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210-599-6016 Fax 210-599-8894

Marge Whatley
Solutions 2000
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Ann Eigler
Diversity Management Services
106 Datonia
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713-665-7314 Fax (Same Number)

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Barbara Bazron, Ph.D.
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703-218-5710

American Society for Training and Development (ASTD)
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Alexandria, Virginia 22313-2043
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Redmond, Washington 98052-5507
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Fax 206-292-2921

Training Programs Director
Cultural Diversity at Work
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Sue Gunderson, Marketing Director
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Marcella Benson-Quaziena
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Dr. Sugunya Sockalingam
5140 Sunrise Beach Road, NW
Olympia, Washington 98504

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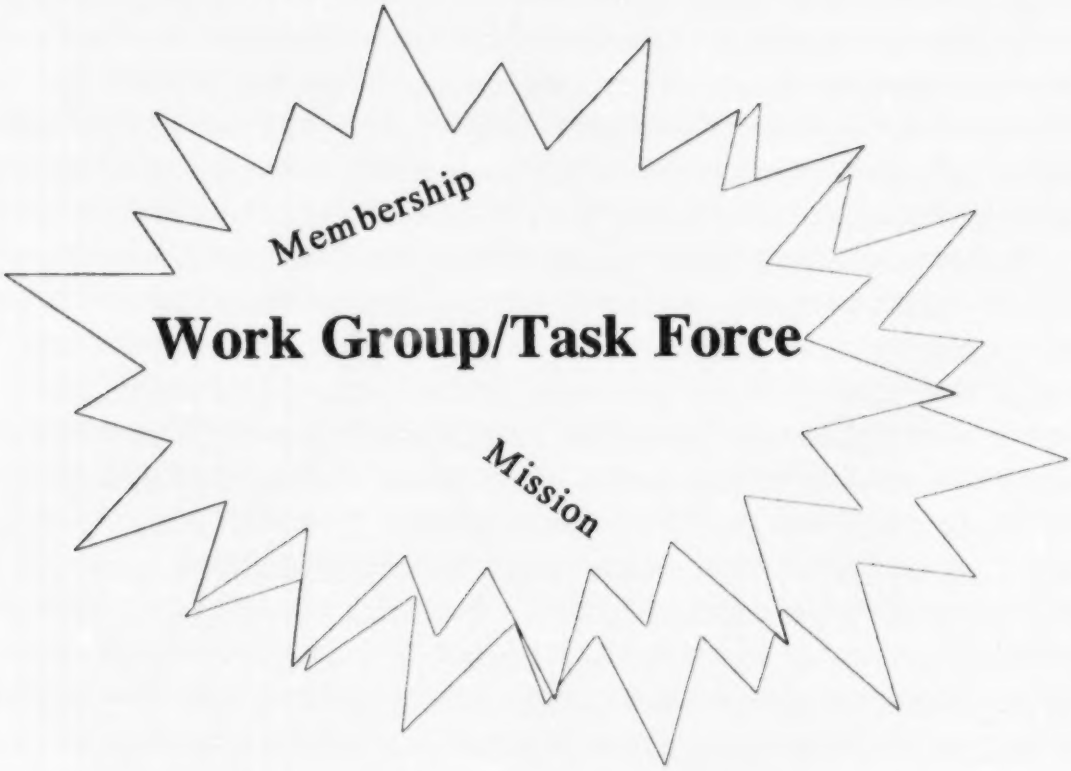
APPENDIX E



OREGON HEALTH DIVISION
February, 1994

GOALS OF THE DIVERSITY DEVELOPMENT TASKFORCE

The taskforce will (1) assess the organization's culture and develop initiatives for creating organization cultural change, (2) establish diversity competencies and develop a training program to assist employees in achieving those competencies, and (3) review and make recommendations on policy and procedural changes.

Goal 1: Assess the organization's culture and develop initiatives for creating organization cultural change.

a. The taskforce will review organizational cultural auditing tools and select one to be used or modified for use to assess the organizational culture of the division.

b. The taskforce will conduct a cultural audit of the division and will analyze the audit results.

c. Based on the audit assessment, the taskforce will develop and initiate a plan including goals, objectives, and timelines to create an organization which is more diverse and inclusive in its organization's cultural values, standards, and norms.

Goal 2: As part of its plan, the taskforce will establish diversity competencies (skills, knowledge, experience, and perspective) and develop a training program to assist employees in achieving those competencies.

a. The taskforce will become familiar with the issues of diversity development through a review of the current literature and by attending informational presentations scheduled for the purpose.

b. Based on the information acquired, the taskforce will develop a list of diversity competencies.

c. The taskforce will design and initiate a training program including priorities, timelines, and outcome measures to assist employees in achieving those competencies.

Goal 3: A component of the plan will be the review of agency policies and procedures to ensure that they do not pose a barrier to diversity development.

a. The taskforce will develop a set of criteria to be used to review agency policies and procedures from a diversity development perspective.

b. Using the criteria, the taskforce will review agency personnel policies and procedures.

c. Based on the review, the taskforce will make recommendations for specific policy and procedural changes and will establish protocols for review of other agency policies and procedures.

DIVERSITY DEVELOPMENT TASKFORCE
OREGON HEALTH DIVISION

Membership Application Interview Questions

Each applicant will be interviewed and asked to respond to the following questions:

1. What skills, knowledge, information, resources, experiences, and perspectives would you bring to the taskforce?

2. What is (are) your culture(s) of origin?

3. Please provide information **you are comfortable in sharing** about your cultural attributes: birthplace, region where reared, age, gender, religious preference, length of service - Health division/state, sexual orientation, socioeconomic status - family of origin/current, physical/mental status, education level, and any other cultural attributes you think relevant.

4. List any cultural group(s) with which you have an informal or formal affiliation (e.g. Masons, Elks, Girl/Boy Scouts, and ethnically based group, a religious or spiritually based group, etc.).

5. Which cultural group(s) would you feel comfortable in representing on the taskforce (e.g. single parents, an ethnic group, babyboomers, working class, a gender group, etc.)?

6. What cultural attribute(s) do you have that, if understood by your co-workers, would improve your working relationships with them?

7. Is there anything you would like to add?

The interview should take between 15 and 30 minutes. The information provided by the interview, combined with the data sheet and matrix, will be used to select members for the taskforce.

CULTURAL COMPETENCE COMMITTEE
REPORT TO FAMILY AND CHILDREN HEALTH SERVICES (F&CHS) PROGRAM MANAGERS

Colorado Department of Health

Proposed Missions Statement:

A mission of the F&CHS Division is to develop the cultural competence of our staff and of the programs we administer and/or support.

Value Statement of the F&CHS Division:

Our division will work toward valuing cultural differences and similarities, without assigning values, in order to apply this sensitivity in planning, implementing, and evaluating services which effectively meet the needs of our diverse clients.

Proposed Actions To Be Taken:

a. Provide cultural awareness/cultural sensitivity training for balance of F&CHS staff.

b. Establish a mechanism to increase communication skills among staff.

c. Develop or adopt an assessment tool to assess cultural competency and identify areas of unmet need of the programs we administer and/or support.

d. Survey local providers and constituencies regarding identified areas of need. Recognizing that courtesy, fear, and other factors may inhibit candid expression of client satisfaction with services, develop culturally appropriate means of making this assessment.

e. Establish a mechanism for assuring reasonable capacity to calls in languages other than English.

f. Establish a mechanism for providing on-going training in cultural competency issues - for management staff as well as health service providers.

g. Establish a mechanism for providing high-quality translation of written materials, including health education materials.

h. Develop mechanisms to encourage increased representation of minorities at all levels - advisory boards, division staffing, local program staffing.

i. Identify and address issues of discrimination and prejudice at all levels.

Role of Cultural Competence Committee:

The role of the Cultural Competence Committee is to facilitate the development of the cultural competence of our division staff and of the programs administered and/or supported by F&CHS.

Proposed Activities:

a. Serve as an information clearinghouse through maintaining a library and preparing a newsletter (semimonthly?)

- ★ training resources
- ★ training materials
- ★ articles
- ★ program initiatives
- ★ best practices
- ★ public and in-house display ("Wall of Pride")

b. Facilitate Ad Hoc sub-committees

- ★ assessment (tools, policy)
- ★ interpretation/translation (policies, resources)
- ★ hiring/recruiting (policies, initiatives)

c. Provide structure for on-going, in-house training

- ★ identify training needs
- ★ identify internal and external training resources
- ★ organize training sessions

Community and Family Health Multicultural Workgroup

MISSION STATEMENT

The mission of the Community and Family Health Multicultural Workgroup is to promote a respectful and inclusive atmosphere where all employees are encouraged to do effective work in assuring optimal health for communities, families, and individuals in the state of Washington.

This two-fold aspect of the workgroup's mission is achieved through the following steps:

1. Promote a respectful and inclusive work atmosphere by:

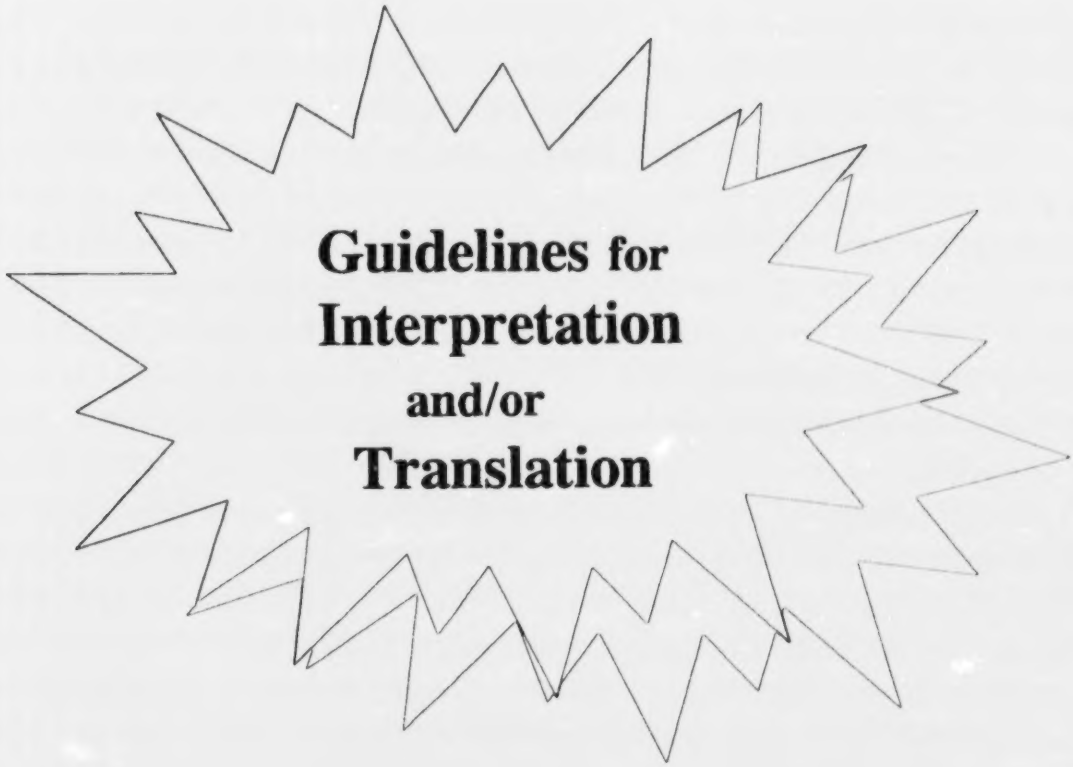
   a. Developing an awareness and understanding of individual differences among employees;
   b. Developing an appreciation of these differences;
   c. Developing acceptance and respect among employees as we work together to achieve our goals.

2. Assure optimal health for communities, families, and individuals by:

   a. Promoting an atmosphere within the agency that encourages employees to recognize the individual differences and needs of all its clients;
   b. Meeting the needs of clients with different health beliefs and norms;
   c. Creating a system that will allow for creative and flexible solutions to meet these health needs.

Washington State Department of Health, Community and Family Health - Mission Statement, Version 3, August 1994

APPENDIX F



FACT SHEET:

WORKING WITH AN INTERPRETER

The expression "dynamics of difference" has been coined to illustrate the interaction between a system belonging to one culture and a population from another. Since both the agency and the client bring a different set of experiences to the interaction, they may also bring culturally-prescribed stereotypes of underlying feelings about serving or being served by someone who is "different". (Denboba 2)

Without an understanding of cross-cultural dynamics, misinterpretation and misjudgment may happen. This misunderstanding occurs on both sides, and is generally rooted in cultural differences.

One way to bridge the cultural and language gap is to use the services of an interpreter. An interpreter is a professional who not only speaks the language of the client and provider, but is also thoroughly familiar with both cultures and well trained in cross-cultural issues. Ideally, he or she should have a background in the health care field, as well as have good interpersonal skills. The interpreter will thus be able to convey the messages and avoid misunderstandings not only in what pertains to language, but also to nonverbal communication. For example, among certain cultures, interpersonal space can be very small. Too great a distance may make the client feel like the provider is being distant, or putting him or herself in a position of superiority. At other times the client, for cultural reasons, may not want to disclose some private information that the provider sees as essential for a better informed diagnosis. A professional interpreter will be able to help in these types of situations.

Using a family member as the interpreter can lead to the client withholding information out of shame or from a desire to keep the information within the family. The provider should always be sensitive to the client's wishes for confidentiality and right to privacy, and make sure the family member is aware of these issues as well.

Helpful hints:

- Meet with the interpreter before the interview to clarify expectations, explain the client's background, and establish a working relationship. At this time the provider should also find out as much as possible about communication techniques in the client's culture such as interpersonal distance, eye contact, proper greeting, and meanings of emotional expressions.
- If possible, the interpreter should meet informally with the client before the date of the formal interview.
- The provider should look at the client, not the interpreter, when either the provider or client is speaking. This will also allow the provider to observe nonverbal communication.
- The interpreter should try to communicate at the client's level, and convey to the provider exactly what the client says without polishing it, omitting anything or adding the interpreter's own ideas or explanations.
- Ask the client to repeat important information to confirm accuracy and understanding.

Denboba, D. (1992). Cultural Competency.

Randall-David, E. (1989) *Strategies for Working with Culturally Diverse Communities and Clients.* Bethesda, Maryland: Association for the Care of Children's Health.

Prepared by the Texas Department of Health, Center on Cultural Competency, 1100 West 49th Street, Austin, Texas 78756 (512) 458-7658

RECOMMENDED PROCEDURE FOR TRANSLATION OF WRITTEN MATERIALS

INTERPRETATION/TRANSLATION COMMITTEE
FAMILY & COMMUNITY HEALTH SERVICES DIVISION
COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
MARCH 1995

The purpose of the following recommendations is to assure the quality and accuracy of translated health education and promotional materials used by the programs of the Family and Community Health Services Division. This will help to assure that the residents of our state who do not read and speak English well will have access to information which may improve their health and well-being.

The recommended translation procedure uses two translators. The first translator provides the original translation. The second translator provides a back translation to English. The back translation step provides a method to review the translation for accuracy and appropriate tone and an opportunity to correct or edit the original. The services of paid, qualified translators should be utilized for the original translation. The back translation should also be done by a qualified translator, who is either paid or is a member of the program's staff. If a member of the program staff is used to provide the back translation, it is recommended that this work duty be included in that individual's job description or PACE.

It is also recommended that the advice of community members, consumers, or staff members who have knowledge of the cultural values of the group for which a translation is being prepared be sought to help to assure the material is understandable, and sensitive to the values of that group or community. A field testing of the translated materials with the actual target audience is also recommended before the final printing of the materials.

Program directors are encouraged to set aside funds in their program budgets to provide for payment for the translation of materials by qualified translators on a fee-for-service basis. Programs are encouraged to utilize translators who have established contracts with the Department. The Translation Subcommittee maintains a listing of qualified translators and welcomes recommendations for additional qualified individuals.

PROGRAM RESPONSIBILITIES:

A designated staff member should be assigned responsibility for the completion of a given translation. That person will be responsible for the preparation of the material to be translated, working with the two translators through the actual translation process, field testing of the translation, and production of the final printed materials.

KEY STEPS IN THE TRANSLATION PROCESS:

1. **Preparation of Material**:

   The material to be translated from English should be carefully selected or written to be at the **literacy level** of the target audience. The general rule for educational materials is to write them at a seventh grade level. The program staff need to determine the literacy level which will be appropriate for the majority of individuals who will utilize the materials.

   A list of the **key messages** should be developed to guide the writing or editing of the English material.

   A **time line** for the completion of the translation, utilizing interim dates for each step, should be developed. A checklist of the Key Steps is attached to assist in this step.

2. **Selecting Translators:**

   A listing of **qualified translators** is available from the F&CHS Translation Committee. These individuals have been oriented to the back translation process and have agreed to participate as described herein. (Programs have the option of obtaining translation services from other translators or through the Spanish Translation Service of the Design Center.)

   The program staff member who is responsible for the particular translation should arrange to **meet with the two translators** at the outset. The translators should be provided information regarding the mission and scope of the program as well as the purpose of the material to be translated. The key health message(s) to be conveyed should be discussed and key words in English, e.g., medical terms that may not be familiar, should be discussed. The literacy level of the target audience and the context in which the materials will be used should be explained. The translators should be encouraged to ask questions and present recommendations which they feel will make the translation understandable and culturally appropriate. The translation should convey the message in the intended tone and should use the natural speech patterns of the second language. Word-for-word translation is discouraged.

3. **Initial Translation:**

   The translator should read and understand the message(s) to be translated; prepare a **first draft** of the translated material; review the translation for accuracy and understandability; edit the draft for typographical, spelling, or grammatical errors.

4. **Back-translation:**

The draft translation should be given to the second translator who also reviews it for accuracy and understandability, spelling, grammar, appropriate tone, and literacy level. The second translator provides a **back translation** into English which is submitted to the responsible program person in writing. Suggestions of corrections or changes which may improve the translation are made to the program person.

If there are **changes** to be made, the program person discusses the proposed changes with both translators who arrive at an agreement as to the final version. If agreement cannot be reached, the staff person makes the decision or seeks the advice of a neutral third party who has experience in reviewing translated materials. The assistance of the Translation Committee is available to provide resources for review of the draft document if there is difficulty in resolving differences of opinion regarding the best translation.

5. **Final Review:**

A field test of the draft translation, through distribution to representatives of the target audience, is recommended. A sample field test questionnaire is attached for use in this step. The draft is returned to the first translator for **final changes** and editing.

6. **Final Production:**

A **final version** is typed or printed for reproduction. The Translation Subcommittee maintains a listing of resources for typing or type-setting in languages which do not use English script.

The final version is reviewed by the original translator for typographical errors. Corrections are made.

The document is sent for reproduction.

7. **Post Production:**

It is requested that copies of final versions of translated materials be sent to the Interpretation/Translation Committee to be included in a resource library for the Division.

This procedure was adapted from the Translation Procedure of the Department of Public Health of the Commonwealth of Massachusetts, developed by that Department's Committee for Culturally and Linguistically Relevant Health Education.

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
FAMILY AND COMMUNITY HEALTH SERVICES DIVISION

PREPARING TO DO TRANSLATIONS:

1. ___ Designate staff person to coordinate translation procedure.

STEPS IN THE TRANSLATION PROCESS:

1. ___ Determine what materials need to be translated and their reading levels.
2. ___ Decide what language(s) to use.
3. ___ Assess literacy level of target group.
4. ___ Develop a list of key health messages to be included.
5. ___ Develop a time-line for translation completion.
6. ___ Choose translators from existing pool of qualified contractors.
7. ___ Review and assign health education material to translators (explain key messages and unfamiliar medial terms) and review translation process.
8. ___ Estimate cost. Current contract rates are $0.18 per translated word. $20.00 per hour is the rate for editing already translated material.

   Count the number of English words, add 20% of the total (the translated document will have more words), and multiply by 2 to include initial and back translations. Typesetting and printing will be an additional and separate cost.

   Formula: Number of English words x 1.2 x $0.18 x 2= Total Estimated Cost.

9. ___ Obtain first draft from first translator and give to second translator.
10. ___ Obtain back-translation (into English) from second translator.
11. ___ Negotiate any changes/discrepancies, if needed.
12. ___ Field test translated material for cultural appropriateness and make any changes.
13. ___ Final review by translator for typographical and other errors before printing.

Time-Lines: Program staff should develop a realistic time-line for the completion of a translation, building in additional time for review and revisions. It usually takes longer than expected to complete a translation.

Selecting Translators: Translation/Interpretation Committee has a listing of translators from which program staff should select. Suggestions for additional translators to supplement the list are welcome. Program staff should meet with both of the translators, if possible, to discuss the purpose of the material and the appropriate reading level of the material for the target population. Program staff should explain the key health messages and review English words (e.g. medical terms that are not familiar to the translators). Staff should encourage the translator to ask any questions she/he has about the translation at any time, and also review rates with the translator.

During the translation: The translator should follow these steps:

a. Read the entire document.
b. Prepare the first draft aiming for full expression of the thoughts.
c. Read the draft aloud for style, rhythm, and flow.
d. Revise and proofread printed copy for errors.

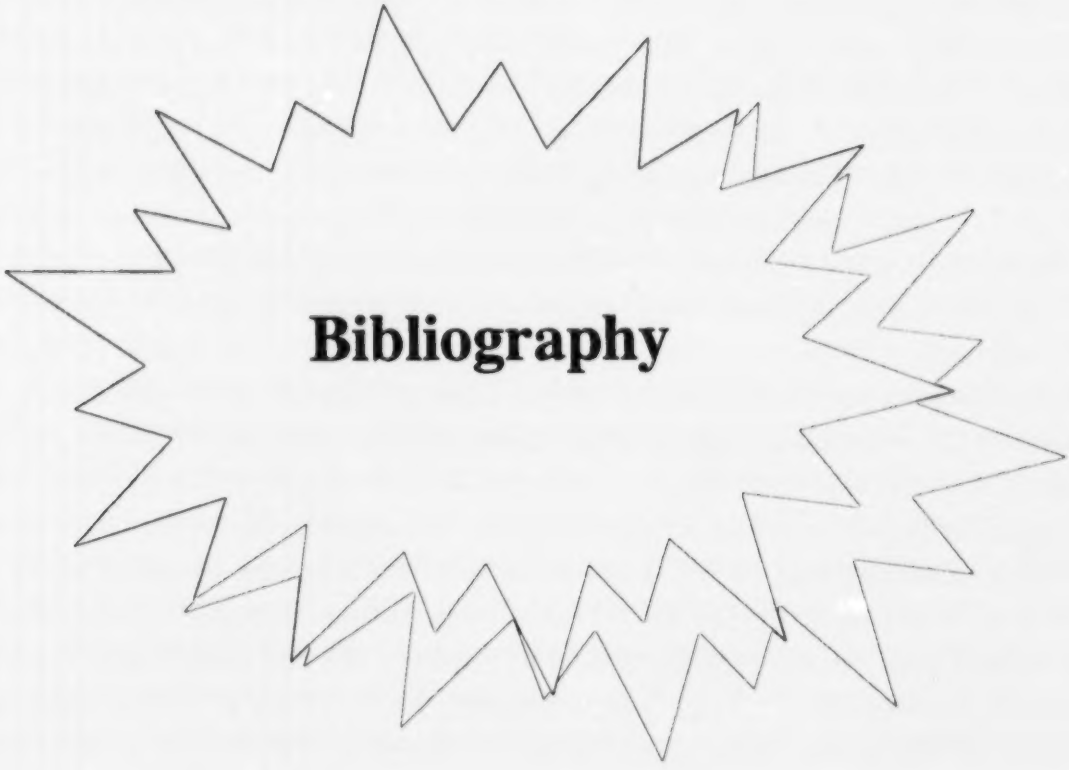
After the initial translation is submitted: The translation should be given to the second translator to check style, grammar, and comprehension of the messages. The second translator should carefully review the literacy level of the translation and provide a back translation from the other language into English, either verbally, over the telephone, or in writing to the program staff person to make sure that the intended messages are clear.

If there are any changes in the translation, the program staff person should arrange a meeting with the two translators to discuss and negotiate these changes. If the translators cannot reach an agreement about the changes, the staff person will be responsible for making a final decision on the translation. The staff person should seek input from a neutral third person who speaks the language and has experience in translation review for a final resolution.

The Translation/Interpretation Committee suggests that the translated material be field tested with members of the target audience. Considerations for whether to field test include available program resources and staff, time-line for the translation, and the purpose and cost of the material.

After final proof is ready: When the final version is ready for reproduction (i.e., a proof for xeroxing or a camera-ready typeset proof for printing), one of the translators should do a final review of this proof for typographical or other errors.

APPENDIX G



Bibliography

Bibliography of Cultural Competency Resources

National MCH Resource Center on Cultural Competency

General Resources

Aday, L.A. 1993. *At risk in America: The health and health care needs of vulnerable populations in the United States.* San Francisco, CA: Jossey-Bass. [Health Series and the Social and Behavioral Science Series]

Allen, J. and Allen, R. 1986. Achieving health promotion objectives through cultural change systems. *American Journal of Health Promotion*, 1(1):42-49.

Benjamin, M. 1994. Research frontiers in building a culturally competent organization. *Focal Point* 8 (2): 17-18.

Bestman, E., et al. 1986. *Culturally appropriate interventions: paradigms and pitfalls.* Paper presented at the 53rd Annual Meeting of the American Orthopsychiatric Association, Atlanta, GA.

Biestek, F.P. 1957. *The casework relationship.* Chicago, Illinois: Loyola University Press.

Breckon, D.J., Harvey, J.R. and Lancaster, R.B. 1985. *Community health education.* Rockville, MD: Aspen Publications.

Brislin, R., and Yoshida, T. 1994. *Intercultural communication training: An introduction.* Thousand Oaks, CA: Sage Publications, Inc.

Bronheim, S.M., Keefe, M.L., and Morgan, C.C. 1993. *Building blocks of a community-based system of care: The Communities Can Campaign experience.* Washington, DC: Georgetown University Child Development Center. [*Communities Can* (volume 1)].

Brownlee, A. 1978. The family and health care: exploration in cross cultural settings. *Social Work in Health Care*. Winter (4):179-199.

Broullon, S., and Williams, C. 1992. *Chapter Outreach Demonstration Project: Reaching out to culturally diverse hemophilia populations.* New York: The National Hemophilia Foundation.

Burns, D.W. 1993. *Connections and connectedness: Cross-cultural theories of development and prevention messages.* New Brunswick, NJ: Rutgers University.

Cafferty, P. and Chestang, L., eds. 1976. *The diverse society: Implication for social policy.* Washington, D.C.: National Association of Social Workers, Inc.

Campinha-Bacote, J. 1991. *The process of cultural competence.* Transcultural C.A.R.E. Associates.

Carpenter, E.M. 1980). Social services, policies, and issues. *Social Casework: The Journal of Contemporary Social Work*, 455-461.

Child Welfare League of America, Inc. 1993. *Cultural competence self-assessment instrument.* Washington, DC.

Christmas, J. 1982. Trying to make it real: Issues and concerns in the provision of services for minorities. In *Perspectives on minority group mental health,* edited by F. Munoz and R. Endo. Washington, DC: University Press of America.

Committee on Minority Health Affairs. 1991. *Racial and cultural bias in medicine.* Kansas City, MO: American Academy of Family Physicians.

Cross, T.L. 1988. Services to minority populations: Cultural competence continuum. *Focal Point*, 3: 1-4.

Cross, T.L., Bazron, B.J., Dennis, K.W., Isaacs, M.R. 1989. *Towards a culturally competent system of care.* Vol. I: A monograph on effective services for minority children who are severely emotionally disturbed. CASSP Technical Assistance Center, Georgetown University Child Development Center.

Davis, T., and O'Malley, M. 1994. *Dealing with differences.* Carrboro, NC: Center for Peace Education.

Davis, T. and Voegtle. 1994. *Culturally competent health care for adolescents.* Chicago, IL: American Medical Association.

Edson, C.H. 1989. Barriers to multiculturalism: Historical perspectives on culture and character in American society. *Coalition Q.*, 6 (2 & 3): 3-9.

Elliott, J.L. 1972. Cultural barriers to the utilization of health services. *Inquiry* 28-35.

Fernandez, John P. 1991. *Managing a diverse work force.* Lexington, MA: Lexington Books.

Flaskerud, J.H. 1986. Diagnostic and treatment differences among five ethnic groups. *Psychological Report* 58(1): 219-35.

_____ The effects of culture-compatible intervention on the utilization of mental health services by minority clients. *Community Mental Health Journal*, 22(2): 127-41.

Freed, A.O. 1988. Interviewing through an interpreter. *Social Work*, 33(4): 315-19.

Futterman, R. 1990. *Cultural competence: Evaluating substance abuse prevention programs for ethnic populations: Bibliography with annotations (Revised).* Rockville, MD: U.S. Department of Health and Human Services, Center for Substance Abuse Prevention.

Gallegos, J.S. 1982. Planning and administering services for minority groups. In *Handbook on mental health administration: The middle manager's perspective*, edited by J.J. Austin and W.E. Hershey. San Francisco: Jossey-Bass, 87-105.

Gonzalez, V.M., Gonzalez, J.T., Freeman, V., and Howard-Pitney, B. 1991. *Health promotion in diverse cultural communities.* Palo Alto, CA: Stanford Health Promotion Resource Center.

Grasska, M., and McFarland, T. 1982. Overcoming the language barrier: Problems and solutions. *American Journal of Nursing,* 82(9), 1376-79.

Green, J.W. et al. 1992. *Cultural awareness in the human services.* New Jersey: Prentice-Hall, Inc.

Greenberg, L. 1992. *State health agency strategies to develop linguistically relevant public health systems.* Washington, DC: Association of State and Territorial Health Officials (ASTHO).

Hanley, J.H. and Barling, P. 1981. Brief problem - Oriented psychotherapy: A model for non-traditional clients. *Journal of Professional Psychology,* 12(5): 556-61.

Harris, N. 1990. Dealing with diverse cultures in child welfare. *Protecting Children* 7(3): 6-7, Fall.

Harwood, A. (1981). *Ethnicity and medical care.* Cambridge, MA: Harvard University Press.

Healthy Mothers, Healthy Babies Coalition. 1990. *Healthy mothers, healthy babies: Supplement to a compendium of program ideas for serving low-income women.* Rockville, MD: Maternal and Child Health Bureau, U.S. Department of Health and Human Services.

Healthy Mothers, Healthy Babies Coalition. 1993. *Unity through diversity: A report on the Healthy Mothers, Healthy Babies Coalition Communities of Color Leadership Roundtable.* Washington, DC: Healthy Mothers, Healthy Babies Coalition.

Henderson, G., and Primeaux, M., eds. 1981. *Transcultural health care.* Menlo Park, CA: Addison-Wesley Publishing Co.

Hendricks, L.E. 1981. Some reflections on racial comparative research. *Urban Research Review* 11(2): 4-15.

Hilliard, A.G. 1980. Cultural diversity and special education. *Exceptional Child*, 46(8): 584-88.

Irish, D., Lundquist, K., Nelson, V., eds. 1993. *Ethnic variations in dying, death and grief: Diversity in universality.* Washington, DC: Taylor and Frances.

Irving, H.B. 1988. *Diet, race and ethnicity in the U.S.: Research and reference materials 1979-1987.* U.S. Department of Agriculture Library. (Quick bibliography series QB 87-27).

Isaacs, M.R. and Benjamin, M.P. 1991. *Towards a culturally competent system of care.* Vol. II: Programs which utilize culturally competent principles. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center. (December).

Issues in culturally competent service delivery: An annotated bibliography. 1990. Portland, OR: Portland State University, Research and Training Center on Family Support and Children's Mental Health.

Janosik, E.H. 1980. Variations in ethnic families. In *Family Focused Care*, edited by J.R. Miller & E.H. Janosik. New York: McGraw-Hill.

Kavanagh, K.H. and Kennedy, P.H. 1992. *Promoting Cultural Diversity: Strategies for Health Care Professionals*. Newbury Park, CA: Sage Publications, Inc.

Kittler, P.G., and Sucher, K. 1989. *Food and culture in America: A nutrition handbook.* Florence, KY: Van Nostrand Reinhold.

Kleinman, A., et al. 1978. Culture, illness, and care: Clinical lessons from anthropological and cross-cultural research. *Annals of Internal Medicine* 88, 251-258.

Kleinman, A. 1978. Concepts and a model for the comparison of medical systems as cultural systems. *Social Science and Medicine* 12:2B, 85. New York: Pergamon Press.

Kumabe, K.T., Nishida, C., & Hepworth, D.H.. 1985. *Bridging ethnocultural diversity in social work and health.* Honolulu, HI: University of Hawaii School of Social Work.

Locke, D. C. 1992. *Increasing multicultural understanding.* Newbury Park, California: Sage Publications, Inc.

Lynch, E.W. and M.J. Hanson, eds. 1992. *Developing cross-cultural competence: A guide for working with young children and their families.* Baltimore, MD: Paul H. Brookes Publishing Co., Inc.

Mason, J. 1994. Developing culturally competent organizations. *Focal Point,* 8 (2): 1-8.

McAdoo, H. P., ed. 1993. *Family ethnicity: Strength in diversity.* Newbury Park, California: Sage Publications, Inc.

Mendel, C.H., and Haberstein, R.W. 1976. *Ethnic families in America.* New York: Elsevier.

Moffett, M., and Wright, L. 1992. *Proceedings from ethnocultural diversity in the 90's influences on health care delivery.* Tallahassee, FL: Children's Medical Services, Florida Department of Health and Rehabilitative Services.

Murray-Seegert, C. 1989. *Nasty girls, thugs and humans like us.* Baltimore, MD: Paul H. Brookes.

National Technical Information Service. 1987. *Strategies for diffusing health information to minority populations.* Springfield, VA.

Nelkin, V.S., et al. 1990. *Improving services for culturally diverse populations: Division activities/FY 1990-1991.* Pathfinders Resources, Inc.

_____. 1990. *Improving state services for culturally diverse populations.* St. Paul, MN: Pathfinders Resources, Inc.

New, P. 1979. Traditions and modern health care: An appraisal of complementarity. *International Social Science Journal* 29(3): 483-93.

Newman, J. M. 1993. *Melting pot: An annotated bibliography and guide to food and nutrition information for ethnic groups in America.* New York & London: Garland Publishing, Inc.

Nidorf J.F., and Morgan, M.C. 1987. Cross cultural issues in adolescent medicine. *Primary Care* 14(1): 69-82.

Orlandi, M., Weston, R. and Epstein, L.G., eds. 1992. *Cultural competence for evaluators.* Rockville, MD: OSAP - U.S. Department of Health.

Orque, M., Block, B., and Monrroy, L. 1983. *Ethnic nursing care: A multicultural approach.* St. Louis, MO: C.V. Mosby Co.

Ossolinski, R.S. 1993. Developing culturally competent policies and services. *Connections: FYSB Youth Gang Prevention Program Update.* Washington, DC: COSMOS Corp.

Pedersen, P. 1988. *A handbook for developing multicultural awareness.* Alexandria, VA: American Association for Counseling and Development.

People of Color Leadership Institute. 1992. *Annotated bibliography of resources on cultural competence and cultural diversity in child welfare/child protection services, and Addendum.* Englewood, Colorado: American Human Association, Children's Division.

People of Color Leadership Institute. 1993. *Training guidebook for developing cultural competence.* Washington, DC.

Phinney, J.S. 1990. Ethnic identity in adolescents and adults: Review of research. *Psychology Bulletin* 108 (3): 499-514.

Putsch, R. 1985. Cross-cultural communications. *Journal of the American Medical Association,* 254, 3344-48.

_____1989. *Strategies for working with culturally diverse communities and clients.* Bethesda, MD: Association for the Care of Children's Health.

Rauch, J.B., North, C., Rowe, C.L., and Risley-Curtiss, C. 1993. *Diversity competence: A learning guide.* Baltimore, MD: School of Social Work, University of Maryland at Baltimore.

Rauch, J., and Curtiss, C. 1992. *Taking a family health/genetic history: An ethnocultural learning guide and handbook.* Baltimore, MD: University of Maryland at Baltimore School of Social Work.

Region X Child Abuse and Neglect Resource Center. 1979. *A Curriculum in cross-cultural awareness for human service workers.* Seattle, WA: Clearinghouse on Child Abuse and Neglect Information.

Rider, M.E. & Mason, J.L. 1990. *Issues in culturally competent service delivery: An annotated bibliography.* Portland, OR: Portland State University, Research and Training Center on Family Support and Childrens's Mental Health.

Roberson, M.H. 1987. Folk health beliefs of health professionals. *Western Journal of Nursing Research,* 9(2), 257-63.

Roberts, C. 1992. *Cultural perspectives on food and nutrition.* Food and Nutrition Information Center, U.S. Department of Agriculture. (Special reference briefs; SRB 92-11).

Scott, C. 1974. Health and healing practices among five ethnic groups in Miami, Florida. *Public Health Reports,* 89(6), 524-32.

Services to minority populations: what does it mean to be a culturally competent professional? 1988. *Focal Point* 2(4). Portland, OR: Research and Training Center, Regional Research Institute for Human Services, Portland State University.

Southwest Communication Resources. 1993. *Culturally responsive services for children and families: A training manual for health and education service providers.*

Spector, R.E. 1991. *Cultural diversity in health and illness.* Appleton & Lange.

St. Denis, G. and Doss, L., eds. 1978. *Health care delivery to meet the changing needs of the American family.* Proceedings of the 1977 Medical Social Consultants Annual Meeting. Pittsburgh, PA: University of Pittsburgh.

Sue, S. and Moore, T., eds. 1982. *The pluralistic society: A community mental health perspective*. New York: Human Sciences Press.

Tafoya, T., and Wirth, D. 1992. *Training for cultural competence: How not to repeat old mistakes.*

Tello, J., et al. 1985. *Developing cultural competence: Awareness, sensitivity, integration, competence.* Los Angeles: Latino Child Sexual Abuse Prevention Project.

The Texas Health Promotion Initiative: A strategic plan responding to diversity. 1991. TX CHPD.

Tripp-Reimer, L. 1982. Barriers to health care: Variations in interpretation of non-Appalachian health professionals. *Western Journal of Nursing Research,* 5(2), 179-91.

U.S. Department of Health and Human Services, Office of Minority Health Resource Center. 1994. *Audiovisuals: Sources of health materials.* Washington, DC: Office of Minority Health, U.S. Department of Health and Human Services.

U. S. General Accounting Office. 1990. *Minority health: Information on activities of HHS's Office of Minority Health.* U. S. General Accounting Office.

Wan, T.H. 1977. The differential use of health services, a minority perspective. *Urban Health* 7, 47-49.

Watkins, E.L. and Johnson, A.E. eds. 1985. *Removing cultural and ethnic barriers to health care.* Based on proceedings of a national conference. Chapel Hill, NC: The Universityof North Carolina at Chapel Hill.

West, C. 1993. *Race matters.* Boston, MA: Beacon Press.

Westover Consultants, Inc. *Second symposium: Developing cultural and ethnic leadership in the field of child abuse and neglect: Summary report.* Washington, DC.

Wolfe, W.S., Bremner, B., and Ferris-Morris, M. 1992. *Monitoring the nutrition of your community: A how-to manual.* Albany, NY: Division of Nutrition, New York State Department of Health.

Yonemitsu, D.M. and Cleveland, J.O. 1992. *Culturally competent service delivery: A training manual for bilingual/bicultural casemanagers.* Southeast Asian Developmental Disabilities Project (SEADD). (October).

Types of Intervention

a) Needs Assessment

Baird, C. 1993. *Linking assessment, service delivery, and outcomes: The CRC case management model.* San Francisco, CA: National Council on Crime and Delinquency.

Mason, J.L. 1993. *The cultural competence self-assessment questionnaire.* Portland, OR: Portland Research and Training Center.

Paniagua, Freddy A. 1994. *Assessing and treating culturally diverse clients* Thousand Oaks, CA: Sage Publications, Inc.

b) Education and Counseling

Almanza, H.P., and Mosley, W.J. 1980. Curriculum adaptations and modifications for culturally diverse handicapped children. *Exceptional Child*, 46(8): 608-614.

Axelson, J. 1985. *Counseling and development in a multicultural society.* Monterey, CA: Brooks-Cole.

Baca, L. 1980. *Policy options for insuring the delivery of an appropriate education to handicapped children who are of limited English proficiency.* The Council for Exceptional Children.

Banks, J.A. 1991. *Teaching strategies for ethnic studies.* (5th ed.). Needham Heights, MA: Allyn and Bacon (A Division of Simon & Schuster, Inc.)

Berlin, E. and Fowkes, W. 1983. A teaching framework for cross-cultural health care. *Western Journal of Medicine,* 139(6), 934-38.

Brislin, R., and Yoshida, T., eds. 1994. *Improving intercultural interactions: Modules for cross-cultural training programs.* Thousand Oaks, CA: Sage Publications, Inc.

Brownlee, A. 1978. *Community, culture and care: A cross-cultural guide for health workers.* St. Louis, MO: C.V. Mosby Co.

Center for Human and Molecular Genetics, Genetic Service Outreach Program. (1993). *Catalog of multilingual patient education materials on genetic and related maternal/child health topics.* Newark, NJ: Center for Human and Molecular Genetics, New Jersey Medical School.

Chess, S., et al. 1984. Selective bias in educational mainstreaming of deaf, intellectually normal adolescents. *Journal of the American Academy of Child Psychiatry*, 23(2): 198-202.

Chinn, P.C. 1984. *Education of culturally and linguistically different exceptional children.* The Council for Exceptional Children.

Dunn, S.K. 1987. *Cross -cultural counseling: Video and leader's guide.*

Gilbert, J. 1972. *A study of equity in providing community mental health services.* New York: Interim report to NIHM by Public Sector, Inc. (September.)

Holmes, L., et al. 1989. *Enhancing cultural awareness and communication skills: A training program for health care providers and educators.* Memphis, TN: Center for Research on Women, Memphis State University. Manual/Videotape.

Jue, S. 1988. AIDS and cross-cultural counseling. *Focus,* 3-4.

Ka'opua, L. 1992. *Training for cultural competence in the HIV epidemic.* Honolulu, HI: Area AETC.

Koslow, D. and Salett, E.P., eds. 1989. *Crossing cultures in mental health.* SIETAR International.

Lee and Richardson, eds. 1990. *Multicultural issues in counseling: New approaches to diversity.* Alexandria, VA: American Association for Counseling and Development.

Luetke-Stahlman, B. 1993. Using bilingual instructional models in teaching hearing-impaired students. *America Annals of the Deaf* 128(7): 873-77.

MacMillan, D.L., Hendrick, I.G. and Watkins, A.V. 1988. Impact of Diana, Larry P, and PL 94-142 on minority students. *Exceptional Child*, 54 (5): 426-432.

MacMillan, D.L. 1988. "New EMRs." (Chapter One). Best Practices in Mental Disabilities. *EDRS* 2.

Munoz, F.U. and Endo, R., eds. 1982. *Perspectives on minority group mental health.* Washington DC: University Press of America, Inc.

National Clearinghouse on Family Support and Children's Mental Health. 1988. *Focal Point* (Fall).

Ortiz, A.A. (1984). *Education of culturally and linguistically different exceptional children.* The Council for Exceptional Children.

Pedersen, P., et al. 1976. *Counseling across cultures.* Honolulu, HI: University Press of Hawaii.

Plata, M., and Jones, P. 1982. Bilingual vocational education for handicapped students. *Exceptional Child* 48(6): 538-40.

Poplin, M.S., and Wright, P. 1983. The concept of cultural pluralism: Issues in special education. *Learning Disabilities Quarterly* 6(4): 367-71.

Randall-David, E. 1994. *Culturally competent HIV counseling and education.* Rockville, MD: National Hemophilia Program.

Rueda, R. 1984. *Education of culturally and linguistically different exceptional children.* The Council for Exceptional Children.

Saunders, M. 1981. Cultural diversity in special education. *Special Education Forward Trends* 8(1): 15-17.

Stewart, D.A., and Benson, G. 1988. Dual cultural negligence: The education of Black deaf children. *Journal of Multicultural Counseling Development* 16(3): 98-109.

Sue, D.W., and Sue, D. 1990. *Counseling the culturally different: Theory and practice.* New York: John Wiley and Sons, Inc.

Sue, D., Arredondo, P., and McDavis, R. 1992. Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development,* 70, 477-486.

Tripp-Reimer, L. 1989. Cross-cultural perspectives on patient teaching. *Nursing clinics of North America.* 24 (3): 613-19.

U.S. Department of Agriculture/Department of health & Human Services. 1986. *Cross-cultural counseling: A guide for nutrition and health counselors.* Alexandria, VA: United States Department of Agriculture. FNS-250. (September).

c) Evaluation

Bailey, D.B. and Harbin, G.L. 1980. Nondiscriminatory evaluation. *Exceptional Child*, 46(8): 590-596.

Kayser, H. 1989. Speech and language assessment of Spanish-English speaking children. *Language, Speech, Hearing Service School.*

Muraskin, L.D. 1993. *Understanding evaluation: The way to better prevention programs.* Rockville, MD: Center for Substance Abuse Prevention, U.S. Department of Health and Human Services.

Nuttall, E.V., et al. 1984. *A critical look at testing and evaluation from a cross-cultural perspective.* The Council for Exceptional Children.

Schensul, J.J. *Avoiding the rocky road to randomization: Multimethod, culturally competent approaches to evaluation in high risk community settings.* Hartford, CT: Institute for Community Research.

Working with People with Special Concerns

a) Children with Special Care Needs

Aliza, B. 1993. *Building systems: A report on Title V programs' collaboration with the Part H early intervention initiative.* Washington, DC: Association of Maternal and Child Health Programs.

Cohen, O.P., Fischgrund, J.E. and Redding R. 1990. Deaf children from ethnic, linguistic and racial minority backgrounds: an overview. *American Annals of the Deaf*, 135(2): 67-73 6 (2&3).

Culture and chronic illness: Raising children with disabling conditions in a culturally diverse world. An invitational conference. 1993. *Pediatrics* 91(5), Part 2, May 1993.

Federation for Children With Special Needs. 1989. A publication of the Technical Assistance for Parent Programs (TAPP) Project. *Coalition Quarterly,* Spr/Sum.

Geber, G., and Latts, E. 1993. Race and ethnicity - Issues for adolescents with chronic illness and disabilities: An annotated bibliography. *Pediatrics*, 9A(5): 107-9.

Huber, M. 1993. *Developing culturally competent programs for children with special needs: Part two.* Albany, NY: New York State Department of Health.

Katz-Leavy, J., et al. 1987. Meeting the mental health needs of severely emotionally disturbed minority children and adolescents: A national perspective. *Child Today* 16(5): 10-14.

Miramontes, O.B. 1990. Organizing for effective paraprofessional services in special education: A Multilingual/Multiethnic Instructional Service team model. *Remedial Special Education*, 12 (1): 29-36, 47.

National Early Childhood Technical Assistance System. 1989. *A bibliography of selected resources on cultural diversity for parents and professionals working with young children who have, or are at risk for, disabilities.*

National Information Center for Children and Youth With Disabilities (NICHCY). 1987. *News Digest* (9).

Pathfinder Resources, Inc. s1993. *Getting help: Developing community-based systems of care for children with special health needs.*

Roach, D. P. 1994. My Grandma's house: Reaching out to underserved families of children and youth with neurobiological, emotional or behavioral differences. *Focal Point* 8, (2): 21-23.

Roberts, R., et al. 1990. *Developing culturally competent programs for families of children with special needs.* Washington, DC: Georgetown University Child Development Center. (September).

Sheppard, R. 1988. *Enhancing child protective service competency: Selected readings II.* In DePanfilis, D., ed. Charlotte, NC: ACTION for Child Protection.

Slade, J.C., and Conley, C.W. 1989. Multicultural experiences for special educators. *Teach Exceptional Child* (Fall).

Yonemitsu, D.M. and Cleveland, J.O. 1992. *Culturally competent service delivery: A training manual for bilingual/bicultural casemanagers.* Southeast Asian Developmental Disabilities Project (SEADD). (October).

b) People with Disabilities

Asbury, C.A., et al. *Disability prevalence and demographic association among race/ethnic minority populations in the United States: Implications for the 21st Century.*

O'Connor, S. 1993. *Multiculturalism and disability: A collection of resources.* Syracuse, NY: Center on Human Policy, Syracuse University.

c) People with Substance Abuse Problems

Center for Substance Abuse Prevention. (1990). *CSAP Prevention Resource Guide: Asian and Pacific Islander Americans.* Rockville, MD: U. S. Department of Health and Human Services.

Colon, E., and Zuckerman, K. 1992. *CSAP Prevention Resource Guide: Hispanic Americans.* Rockville, MD: U.S. Department of Health and Human Services.

Working with Different Population Groups

a) African Americans

Black Americans

Brisban, F.L., and Womble, M. (1993). *Working with African-Americans: The professional's handbook.* Chicago, IL: HRDI International Press.

Dennis, R., & Kirk, A. 1976. Survey of the use of crisis intervention centers by the black population. *Suicide and Life Threatening Behavior,* 6(2), 101-04.

Hill, R. 1972. *The strengths of black families.* New York: Emerson Hall.

Jackson, J. 1981. Urban black Americans. In *Ethnicity and medical care*, edited by A. Harwood, (pp. 37-129). Cambridge, MA: Harvard University Press.

King, J. 1979. African survivals in the black American family: Key factors in stability. In *Understanding and counseling ethnic minorities,* edited by G. Henderson, (pp. 43-59). Springfield, IL: Charles C. Thomas.

Kuna, R. 1977. Hoodoo: The indigenous medicine and psychiatry of the black American. *Mankind Quarterly,* 18(2), 137-51.

Lowery, E. 1987. AIDS and the black community. Southern Christian Leadership Conference/W.O.M.E.N. Atlanta, GA: BAC Printing Co.

McAdoo, H. P., ed. 1988. *Black families.* Newbury Park, California: Sage Publications, Inc.

Randall-David, E. 1985. *"Mama always said": The transmission of health care beliefs among three generations of rural black women.* Doctoral Dissertation, University of Florida, Gainesville.

Smith, E. 1981. Cultural and historical perspectives in counseling blacks. In D. Sue, ed., *Counseling the culturally different* (pp. 141-85). New York: John Wiley and Sons.

Straight, W. 1983. Throw downs, fixin, rooting and hexing. *Journal of Florida Medical Association,* 70(8), 635-41.

Tingling, D. 1967. Voodoo, rootwork, and medicine. *Psychosomatic Medicine,* 29(5), 483-90.

U.S. Department of Health and Human Services, Office of Minority Health Resource Center. 1994. *African Americans: Sources of health materials.* Washington, DC: Office of Minority Health, U.S. Department of Health and Human Services. Contact: Office of Minority Health Resource Center, P. O. Box 37337, Washington,DC 20013-7227. Telephone: (800) 444-6472 or (301) 587-1938. Available at no charge.

Walter, D. 1986. AIDS in the black community. *The Advocate,* 2, 10-11, 20-21.

Weintraub, R. 1973. The influence of others: Witchcraft and rootwork as explanations of behavior disturbances. *Journal of Nervous and Mental Disease,* 156(2), 318-26.

Haitians

Bestman, E., Lefley, H., & Scott, C. 1976, March. *Culturally appropriate intervention: Paradigms and pitfalls.* Paper presented at the 53rd Annual Meeting of the American Orthopsychiatric Association, Atlanta, GA.

Laguerre, M. 1981. Haitian Americans. In *Ethnicity and medical care,* edited by A. Harwood, (pp. 172-210), Cambridge, MA: Harvard University Press.

Scott, C. 1973, November. *Haitian blood beliefs and practices in Miami, Florida.* Paper presented at the American Anthropological Association Meeting. New Orleans, Louisiana.

b) Amish

Armstrong, P., & Feldman, S. (1986). A *midwife's story.* New York: Arbor House.

Gingerich, O. 1972. *The Amish of Canada.* Waterloo, Ontario: Conrad Press.

Hostetler, J. 1980. *Amish society.* Baltimore: Johns Hopkins.

Huntington, G. 1976. The Amish family. In *Ethnic families in America,* edited by C. H. Mendel & R. W. Haberstein. New York: Elsevier.

Rice, C. S., & Steinmetz, R. C. 1956. *The Amish year.* New Brunswick: Rutgers University Press.

Smith, E. 1958. *The Amish people.* New York: Exposition University Press.

Smith, E. 1960. *Studies in Amish demography.* Harrisonburg, VA: Research Council, East Mennonite College.

Warner, J., & Denlinger, D. 1969. *The gentle people: A portrait of the Amish.* New York: Grossman Publishers.

Wittmer, J. 1970. Homogeneity of personality characteristics: A comparison between Old Order Amish and Non-Amish. *American Anthropologist,* 72, 1063-67.

c) Asian Americans and Pacific Islanders

Association of Asian/Pacific Community Health Organizations. 1987. *Health education materials in Asian languages: Maternal and Child Health topics: Catalog of evaluated materials.* Oakland, CA: Association of Asian/Pacific Community Health Organizations.

Fuller, J. 1986. *Health and social beliefs of one Vietnamese-American family.* Unpublished paper, University of Florida, College of Nursing.

Khoa, L. X., et al., Southeast Asian social and cultural customs: Similarities and differences. *Journal of Refugee Resettlement,* 27-46.

Khoa, L. X., & Vandeusen, J. Social and cultural customs: Their contribution to resettlement. *Journal of Refugee Resettlement,* 48-52.

McKenzie, J., & Chrisman, N. 1977. Healing herbs, gods, and magic: Folk health beliefs among Filipino-Americans. *Nursing Outlook,* 25(5), 326-29.

Min, Pyong Gap, ed. 1995. *Asian Americans: Contemporary trends and issues.* Thousand Oaks, California: Sage Publications, Inc.

Okello, R. 1991. *Increasing numbers of Southeast Asians receiving comprehensive health care services project: Training manual.* Providence, RI: Rhode Island Department of Health.

Rosenberg, J.A. 1986. Health care for Cambodian children: Integrating treatment plans. *Pediatric Nursing,* 12(2), 118-25.

Santopietro, M., & Smith, C. 1981. How to get through to a refugee patient. *RN Magazine,* 43-48.

Sue, D. 1981. Cultural and historical perspectives in counseling Asian Americans. In D. Sue (Ed.), *Counseling the culturally different: Theory and practice,* (pp. 113-40). New York: John Wiley & Sons.

Toupin, E., & Ahn, S. W. 1980. Counseling Asians: Psychotherapy in the context of racism and Asian American history. *American Journal of Orthopsychiatry,* 50(1), 76-86.

U.S. Department of Health and Human Services, Office of Minority Health Resource Center. 1994. *Asian languages: Sources of health materials.* Washington, DC: Office of Minority Health, U.S. Department of Health and Human Services. Contact: Office of Minority Health Resource Center, P. O. Box 37337, Washington,DC 20013-7227. Telephone: (800) 444-6472 or (301) 587-1938. Available at no charge.

U.S. Department of Health and Human Services, Office of Minority Health Resource Center. 1994. *Pacific Islanders: Sources of health materials.* Washington, DC: Office of Minority Health, U.S. Department of Health and Human Services. Contact: Office of Minority Health Resource Center, P. O. Box 37337, Washington,DC 20013-7227. Telephone: (800) 444-6472 or (301) 587-1938. Available at no charge.

Vandeusen, J, et al. Southeast Asian social and cultural customs: similarities and differences. Part 1, *Journal of Refugee Resettlement,* 20-39.

d) Hispanic/Latinos

Auger and Colindres. 1994. *Latino cultural competency manual.* Washington, DC: ASTHO.

Carpio, B., Carpio-Cedraro, and Anderson, L. 1990. Hispanic families learning and teaching about AIDS: A participatory approach at the community level. *Hispanic Journal of Behavioral Sciences,* 12(12), 165-76.

COSSMHO. 1990. *Delivering preventive health care to Hispanics: A manual for providers.* Washington, DC: The National Coalition of Hispanic Health and Human Services Organizations.

Ruiz, R. 1981. Cultural and historical perspectives in counseling Hispanics. In D. Sue (Ed.), *Counseling the culturally different: Theory and practice* (pp. 186-215). New York: Wiley.

Ruiz, R. A., & Padella, A. M. 1977. Counseling Latinos. *The Personnel and Guidance Journal, 55,* 401-408.

U.S. Department of Health and Human Services, Office of Minority Health Resource Center. 1994. *Spanish language: Sources of health materials.* Washington, DC: Office of Minority Health, U.S. Department of Health and Human Services.Contact: Office of Minority Health Resource Center, P. O. Box 37337, Washington,DC 20013-7227. Telephone: (800) 444-6472 or (301) 587-1938. Available at no charge.

Cuban Americans

Sandoval, M. 197). Afro Cuban concepts of disease and its treatment in Miami. *Journal of Operational Psychiatry, 8*(2), 52-63.

Sandoval, M. 1979. Santeria as a mental health care system. *Social Science and Medicine, 138,* 137-51.

Sandoval, M. 1983. Santeria. *Journal of the Florida Medical Association, 70*(8), 620-28.

Mexican-Americans

Aquilar, I. 1972. Initial contacts with Mexican-American families. *Social Work, 17*(3), 66-70.

Clark, M. 1959. *Health in the Mexican-American Culture: A Community Study.* Berkeley: University of California Press.

Clark, M. 1979. Mexican-American family structure. In *Understanding and counseling ethnic minorities,* edited by G. Henderson, (pp. 264-335). Cambridge: Harvard University Press.

Cueller, I., et al. 1980. An acculturation scale for Mexican American normal and clinical populations. *Hispanic Journal of Behavioral Sciences*, 2(3): 199-217.

Gilbert, M.J. and Cervantes, R.C. 1986. Alcohol services for Mexican Americans: A Review of utilization patterns, treatment considerations, and prevention activities. *Hispanic Journal of Behavioral Science*, 8(3): 191-223.

Gomez, E. and Cook, K. 1978. Chicano culture and mental health services: Trees in search of a forest. In *Chicano Culture and Mental Health*, edited by E. Gomez. San Antonio, TX: Our Lady of the Lake University.

Schreiber, J., & Homiak, J. 1981. Mexican Americans. In *Ethnicity and Medical Care,* edited by A. Harwood, (pp. 264-335). Cambridge: Harvard University Press.

National Resource Center on the Mexican American Family. 1985. *Developing cultural competence: Awareness, sensitivity, integration, competence. A training manual for improving the efficiency and effectiveness of social services delivered to Mexican American families.* Laredo, TX.

Wood, P.R. 1987. *Communicating with adolescents from culturally varied backgrounds: a model based on Mexican-American adolescents in South Texas*. Semin. Adolescent Medicine.

Puerto Ricans

Christensen, E. W. 1977. When counseling Puerto Ricans. *Personnel and Guidance Journal, 55,* 412-15.

Christensen, E. W. 197). Counseling Puerto Ricans: Some cultural considerations. In *Understanding and Counseling Ethnic Minorities,* edited by G. Henderson, (pp. 269-79). Springfield, IL: Charles C. Thomas.

Delgado, M. 1979. Puerto Rican spiritualism and the social work profession. In *Understanding and Counseling Ethnic Minorities,* edited by G. Henderson, (pp. 216-31). Springfield, IL: Charles C. Thomas.

Harwood, A. 1981. Mainland Puerto Ricans. In *Ethnicity and medical care,* edited by A. Harwood, (pp. 397-481). Cambridge, MA: Harvard University Press.

e) Native Americans

Commission on Indian Services. 1984. *Summary of general issues and concerns relating to state human resources programs as identified by the American Indian Community of Oregon.* Report of the Commission on Indian Services and Their Assessment of Human Resource Services to American Indians in the State of Oregon. Salem, OR.

Cross, T.L. 1986. *Gathering and sharing: An exploratory study of service delivery to emotionally handicapped Indian children.* Research and Training Center to Improve Services for Seriously Emotionally Handicapped Children and their Families. Portland, OR: Northwest Indian Child Welfare Institute, Portland State University.

Edwards, E.D. and Edwards, M.E. 1980. American Indians: Working with individuals and groups. *Social Casework: The Journal of Contemporary Social Work,* 498-506.

Farris, C.E., et al. 1980. Self concept formation in Indian children. *Social Casework: The Journal of Contemporary Social Work,* 484-89.

Goodluck, C.T. and Short, D. 1980. Working with American Indian parents: A cultural approach. *Social Casework: The Journal of Contemporary Social Work,*, 472-75.

Hammerschlag, C.A. 1982. American Indian disenfranchisement: Its impact on health and health care. *White Cloud Journal,* 2(4): 32-36.

Hanson, W. 1980. The urban Indian woman and her family. *Social Casework: The Journal of Contemporary Social Work,* 476-83.

Horan, K.T. 1986. Effects of head injury on the educational and vocational potential of American

Indians. *Rural Special Education Quarterly* 8(1): 19-22.

Kunitz, S., & Levy, J. 1981. Navajos. In *Ethnicity and medical care,* edited by A. Harwood, (pp.337-97). Cambridge, MA: Harvard University Press.

LaFromboise, T.D. 1988. American Indian mental health policy. *American Psychologist* 43(5): 388-397.

LaFromboise, T.D. and Plake, B.S. 1984. A Model for the Systematic Review of Mental Health Research: American Indian Family, a Case in Point. *White Cloud Journal,* 3(3): 44-52.

Lewis, R.G. and Gingerich, W. 1980. Leadership characteristics: Views of Indian and non-Indian students. *Social Casework: The Journal of Contemporary Social Work,* 494-497.

Miller, D.L., et al. A perspective on the Indian Child Welfare Act. *Social Casework: The Journal of Contemporary Social Work,* 1980, 468-71.

O'Connell, J.C., and Johnson, M.J. 1986. *Native American rehabilitation: A bibliographic series.* Flagstaff, AZ: Northern Arizona University.

Primeaux, M. 1977. Caring for the American Indian patient, *American Journal of Nursing, 77,* 91-96.

Red Horse, J.G. 1980. American Indian Elders: Unifiers of Indian families. *Social Casework: The Journal of Contemporary Social Work,* 490-493.

_____ 1980. Family structure and value orientation in American Indians. *Social Casework: The Journal of Contemporary Social Work,* 462-467.

Red Horse, J., Lewis, R., Feit, M., & Decker, J. 1978. Family behavior of urban American Indians. *Social Casework, 59,* 67-72.

Richardson, E. 1981. Cultural and historical perspectives in counseling American Indians. In *Counseling the culturally different,* edited by D. Sue, (pp. 216-55). New York: John Wiley and Sons.

Ronnau, J., and Shannon, P. 1990. A strengths approach to helping Native American families. *Indian Child Welfare Digest* 15-17, February/March 1990.

Thomas, S.N. 1972. *Culture based curriculum for young Indian children.*

Southwest Productions, Inc. *Finding the balance.* Albuquerque, NM: Southwest Communications Resources, Inc. **Video.**

Southwest Productions, Inc. *Listen with respect.* Southwest Communications Resources, Inc., Albuquerque, NM. **Video.**

Trimble, J. 1976. Value differentials and their importance in counseling American Indians. In *Counseling across cultures,* edited by P. Pedersen, J. Draguns, W. Lonner, & J. Trimble, (pp. 201-26). Honolulu: University Press of Hawaii.

U.S. Department of Health and Human Services, Office of Minority Health Resource Center. 1994. *Native Americans: Sources of health materials.* Washington, DC: Office of Minority Health, U.S. Department of Health and Human Services. Contact: Office of Minority Health Resource Center, P. O. Box 37337, Washington,DC 20013-7227. Telephone: (800) 444-6472 or (301) 587-1938. Available at no charge.

Wilkinson, Gerald Thomas. 1980. On assisting Indian people. *Social Casework: The Journal of Contemporary Social Work* 451-454.

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